Iowa Medicaid Enterprise State Medicaid HIT Plan

January 2021

V9.1

Change History

Date:	Changed By:	Changes:	Version:
9/08/2010	Jody Holmes Kelly Peiper Dane Pelfrey	Completed version 1.0 for submission to CMS	1.0
11/08/2010	Kelly Peiper Dane Pelfrey	Updated SMHP per Appendix Y - CMS SHMP Approval letter dated Oct 12, 2010 – Enclosures A & B	1.1
7/14/2011	Jody Holmes Kelly Peiper	The Medicaid enrollment numbers and graphs have been updated. Strategic Planning section has been updated to reflect current status. HIE Background has been updated to reflect ONC grant. Update on the Regional Extension Center progress. Section A has been updated to reflect the most recent assessment information. A section was added on the Community College Consortium. Section B was updated to reflect current information from additional planning for the Health Information Exchange by the stakeholder group. Section C has been updated to note the Iowa progress on the EHR incentive program. Section C now includes lessons learned. Section C process flows have been updated to reflect changes made to the process following implementation. Section D has been modified to identify changes to the pre-payment audit strategy. The section E roadmap has been updated to reflect new timelines, and notes which tasks have been completed. Each section has been reviewed and a status update note added to reflect progress on the goals and action items. The tables with	2.0

		specific timelines have been updated to reflect the shift in deliverable timeframes. Appendix. The sections from the Iowa e-Health strategic and operational plan have been removed. The updated plan can be reviewed at www.iowaehealth.org The project abstract for the Immunization and lab grants have been removed. The hospital calculator has been updated The Iowa Administrative Code rules section has been updated to reflect the current rules. The provider agreement has been included as appendix F, including the PA addendum. Appendix G has been added to show the providers who have expressed interest in participating in the HIE, by provider type. Appendix H has been added to show the questions for Meaningful Use attestation.	
9/19/2011	Jody Holmes	Modify Appendix F, to clarify language in sections II and IV	2.1
8/01/2012	Kelly Peiper	Annual update Updated hospital calculator Modify language in Section C to reflect current processes	3.0
9/13/2013	Jody Holmes Rachel Lunsford	Annual update Modified background to reflect the new Iowa Health and Wellness Plan Added State Innovation Model Design to the Background Updated Section A with general updates on as-is landscape and specific updates on AIU and MU rates Updated Section C to reflect stage 2 changes Modified language in Section D to reflect changes requested in a letter dated December 4, 2012 regarding changes to Iowa's comprehensive audit strategy	4.0

		Updated strategy to reflect changes to Stage 1 and new Stage 2 rules Defined audit approach for each meaningful use measure Provided auditor checklists Define risk pools for audit strategy Indicated state use of E7/E8 process Updated Section E to reflect shift in strategy for technical assistance and provided general updates in our roadmap	
11/21/2013	Rachel Lunsford	Included the summary of the Stage 2 Regulations Changes which starts on page 77 in the clean version and 107 in the marked up version.	4.1
7/21/2014	Tanya McAninch Carrie Ortega	Added screen shots of audit templates Updated screen shots to reflect current requirements for Stage 1 & Stage 2 Added languages of E7 (audit) Defined risk categories total 5% of previous quarter broken down into -50% high, 30% mod, 20% low Put into production for providers to attest for stage 1 and stage 2 Removed Section D – Iowa's Incentive Payment Audit Strategy to a separate document.	5.0
9/25/2015	Carrie Ortega	Updated Iowa Medicaid Enterprise background section, Updated Section A: to include broadband maps as well as EHR adoption and return rates for AIU and MU, included IHIN updates, updated number of eligible providers enrolled in Medicaid and licensed eligible providers in the state of Iowa, elaborated on hospital program participation, included CEHRT information. Section B: Change on horizon with IHIN and MCOs, addition of next 12-15 months plan. Section C: Included 2014 flexibility rule.	6.0

		Section E: Updated 2014-2016 actions and status.	
1/2016	Carrie Ortega	SMHP Addendum to support 2015-2017 Modifications and Stage 3 Final Rule published on October 16, 2015.	
2/2017	Carrie Ortega	SMHP addendum to support final rule, the 2015-2017 Modifications and Stage 3 Final Rule published on October 16, 2015, the Outpatient Prospective Payment System (OPPS) rule published on November 14, 2016, and the MACRA/MIPS Final Rule issued on October 14, 2016.	
10/2017	Carrie Ortega	SMHP Section D updates	7.0
10/2019	Carrie Ortega	Updated: Rebaselined SMHP As-Is, To-Be, HIT Roadmap, updates to all sections (A-E)	8.0
10/2020	Carrie Ortega	Minor updates throughout document Section A includes information regarding the final environmental scan Section C includes a timeline of administrative closeout activities.	9.0
1/2021	Carrie Ortega	Addition of 2.9.1 Process for Public Health Data Registry Collection via HIE Corrected count of FQHCs attesting for MU and AIU in section 2.3	9.1

Table of Contents

CHANGE HISTORY 2
1 DOCUMENT PURPOSE 10
1.1 KEY STAKEHOLDERS 10
1.2 AUDIENCE 10
1.3 IOWA MEDICAID ENTERPRISE PROGRAM BACKGROUND 11
2 SECTION A: IOWA'S "AS-IS" HIT LANDSCAPE 12
2.1 ELECTRONIC HEALTH RECORD (EHR) ADOPTION 12
2.1.1 Survey Results – EHR Adoption and Use, Health Information Exchange 12
2.1.2 Survey Results – IME Member Services Survey 15
2.1.3 Iowa Medicaid Promoting Interoperability Program Provider Targets & Attestation 16
2.1.4 CEHRT Used in Iowa 22
2.2 BROADBAND ACCESS 23
2.2.1 Broadband and the Office of the Chief Information Officer (OCIO) 23
2.2.2 Iowa HF772 - Empower Rural Iowa Act 24
2.2.3 Broadband Grants 24
2.2.4 BroadbandNow 25
2.2.5 Connected Nation Iowa 26
2.2.6 Iowa Communications Network (ICN) 26
2.3 FEDERALLY QUALIFIED HEALTH CENTERS 26
2.4 VETERANS ADMINISTRATION & INDIAN HEALTH SERVICES 27
2.5 HEALTH INFORMATION TECHNOLOGY AND HEALTH INFORMATION EXCHANGE 27
2.5.1 Iowa Health Information Network (IHIN) 27
2.5.2 IHIN Operations under IDPH 28
2.5.3 IHIN Non-Profit Entity 33
2.5.4 Governor's Healthcare Innovation and Visioning Roundtable 36
2.5.5 State Laws or Regulations Impacting Promoting Interoperability Program 37
2.6 STATE MEDICAID AGENCY MMIS AND HIT/E RELATIONSHIPS 38
2.6.1 Current Medicaid Information Technology Architecture 38
2.6.2 SMA HIT/E Relationships with Other Entities 40
2.6.3 Patient Centered Medical Home 40

2.7 SMA'S RELATIONSHIP TO THE STATE HIT COORDINATOR 40
2.8 STATE BORDERS AND HEALTH INFORMATION TECHNOLOGY OR EXCHANGE 41
2.9 STATE IMMUNIZATION & PUBLIC HEALTH SURVEILLANCE 41
2.9.1 Process for Public Health Data Registry Collection via HIE 42
2.10 GRANTS 42
2.10.1 State Innovation Model Grant 42
3 SECTION B: IOWA'S "TO-BE" HIT LANDSCAPE 44
3.1 OVERVIEW 44
3.2 IME- FIVE YEAR GOALS 44
3.2.1 Increase Provider adoption of Electronic Health Records (EHR) and Health Information Exchange 44
Objectives: 45
3.2.2 Improve Administrative Efficiencies and Contain Costs 45
Objectives: 45
3.2.3 Improve Quality Outcomes for Members 46
Objectives: 46
3.2.4 Improve Member Wellness 46
Objectives: 46
3.3 MEDICAID INFORMATION TECHNOLOGY ARCHITECTURE TO-BE WITHIN NEXT 5 YEARS 46
3.4 ISSUES TO BE ADDRESSED WITHIN THE NEXT FIVE YEARS TO ACHIEVE GOALS 50
3.4.1 Other Issues which would need to be addressed to Achieve Broad Health Information Exchange and Interoperability 50
3.5 HEALTH INFORMATION EXCHANGE TO ACHIEVE IME'S HIT/E GOALS AND OBJECTIVES 50
3.6 PROMOTING INTEROPERABILITY PROGRAM INTERFACE WITH MMIS 51
3.7 PROMOTING INTEROPERABILITY PROGRAM – ENCOURAGE PROVIDER ADOPTION/USE OF CEHRT 51
3.8 PROMOTING INTEROPERABILITY PROGRAM – ADDRESSING POPULATIONS WITH UNIQUE NEEDS, SUCH AS CHILDREN 51
3.9 LEGISLATION CHANGES TO EXISTING STATE LAWS TO IMPLEMENT EHR INCENTIVE PROGRAM OR HEALTH INFORMATION EXCHANGE 52
3.10 HIT-RELATED GRANT AWARDS IMPACT ON PROMOTING INTEROPERABILITY PROGRAM 52
4 SECTION C: IOWA'S EHR INCENTIVE PAYMENT PROGRAM 53

4.1 OVERVIEW 53
4.1.1 IME Implementation of Promoting Interoperability Program & Contractors 53
4.2 OUTREACH AND PROVIDER SUPPORT 53
4.2.1 Support through Prepayment Process 53
4.2.2 Outreach Activities 54
4.2.3 Provider Resources 56
4.2.4 Hospital Outreach 56
4.2.5 Dentist Outreach 57
4.2.6 Lessons Learned 57
4.3 STATE MEDICAID AGENCY OPTIONS 58
4.4 PROMOTING INTEROPERABILITY PROGRAM ATTESTATION AND PRE-PAYMENT AUDIT PROCESS 58
4.4.1 Provider Registration and Attestation 58
4.5 ATTESTATION TAIL PERIOD 62
4.6 PREPAYMENT AUDIT PROCESS 62
4.6.1 Meaningful Use Pre-payment Verification 66
4.6.2 Incentive Payment Assignment 66
4.6.3 Incentive Payment Amounts for EPs 66
4.6.4 Hospitals 67
4.6.5 Payment Frequency 68
4.6.6 Communication to Providers Regarding Eligibility, Payments, etc. 68
4.7 SYSTEMS 69
4.7.1 CMS Registration and Attestation Site 69
4.7.2 PIPP System Updates 69
4.7.3 CMS Dependencies 71
4.7.4 Medicaid Management Information System (MMIS) 71
4.8 MMIS ENHANCEMENTS 72
4.9 APPEALS 75
4.10 CLAIMING FFP 78
4.11 PROMOTING INTEROPERABILITY PROGRAM SUNSET ACTIVITIES 79
5 SECTION E: IOWA'S HIT ROADMAP 80
5.1 OVERVIEW 80

5.2 DESCRIPTION OF PATHWAY 80
5.2.1 Modernizing and Transforming the MMIS 80
5.2.2 Administer Medicaid EHR Incentive Payment 82
5.2.3 Support Health Information Exchange 82
5.3 EVOLVING HIT/E ROADMAP 85
6 APPENDICES 86
6.1 PIPP SYSTEM WORKFLOWS 86

1 Document Purpose

The Iowa Medicaid Enterprise (IME) updated the State Medicaid Health Information Technology Plan (SMHP) as a deliverable to the Centers for Medicare and Medicaid Services (CMS) to continue operation of Iowa's Promoting Interoperability Program (formerly known as the Electronic Health record or EHR incentive payment program). The updated SMHP describes how IME will continue to administer the program, as authorized under section 4201 of the American Reinvestment and Recovery Act (ARRA). The SMHP outlines the Health Information Technology (HIT) initiatives the IME believes will encourage the adoption and meaningful use of certified EHR technology and promote health information exchange and interoperability. The IME will use the SMHP as a tool to improve the quality of healthcare our members receive through the exchange of health care information.

This SMHP serves as the IME's strategic Health Information Technology (HIT) planning document for the HITECH program. The IME expects that medical advances, HIT advances, federal and state legislation, and provider needs will continue to evolve. The IME will revise the SMHP on an annual basis to show a rolling five (5) year vision of HIT needs within Iowa. This annual revision cycle aligns the needs of the IME's members, provider network, and HIT investments.

The IME recognizes that the funding of the individual projects and technologies within this document may come from different sources – Medicaid Management Information System (MMIS) Funding, HITECH Funding, State Funding Grants, etc. Funding for individual projects will be determined as part of the project planning and kickoff activities.

1.1 Key Stakeholders

Julie Lovelady, Iowa Medicaid Interim Director

Iowa Medicaid Enterprise Policy and Contracting Staff

IME Members

IME Providers

1.2 Audience

Centers for Medicare and Medicaid Services (CMS)

Iowa Department of Public Health (IDPH)

Iowa Health Information Network (IHIN)

Office of the National Coordinator for Health Information Technology (ONC)

1.3 Iowa Medicaid Enterprise Program Background

Medicaid is an entitlement program designed to provide medical care to low-income individuals who are aged, blind, or disabled, pregnant, under 21 years of age, or members of a family with dependent children. The program was authorized under Title XIX of the Social Security Act of 1965. The Medicaid program is funded jointly by the state and federal governments.

To be eligible for Medicaid, individuals must be low-income and fall into one of the federally mandated categories: children, frail elderly, disabled persons, pregnant women, or very low-income parents. Iowa Medicaid Enterprise (IME)[1] is responsible for administering the Iowa Medicaid Program. It exists under the Iowa Department of Human Services and is staffed with state employees and professional services vendors, who work cooperatively with the Department staff to perform the Medicaid functions[2].

Iowa Medicaid has three main coverage groups[3]:

- IA Health Link (managed care program)
- Medicaid Fee-for-Service
- Hawki (Healthy and Well Kids in Iowa)

Most Iowa Medicaid members are enrolled in the IA Health Link managed care program. These members receive health coverage from a Managed Care Organization (MCO) they choose. Hawki members receive their benefits through an MCO they choose. Some members continue to receive Medicaid Fee-for-Service. The Iowa Health and Wellness Plan[4] provides comprehensive health coverage at low or no cost to Iowans between the ages of 19 and 64; eligibility is based on household income.

[1] See https://dhs.iowa.gov/ime/about for more information on Iowa Medicaid Enterprise
[2] Iowa Medicaid Enterprise Units https://dhs.iowa.gov/ime/about/aboutime
[3] See https://dhs.iowa.gov/ime/members/who-receives-medicaid for more information on coverage groups
[4] See https://dhs.iowa.gov/ihawp for more information on Iowa Health and Wellness Plan

2 Section A: Iowa's "As-Is" HIT Landscape

This overview of Iowa's "As-Is" HIT landscape describes the level of Health IT adoption by Iowa's health care providers.

2.1 Electronic Health Record (EHR) Adoption

This section contains information about multiple survey results, Promoting Interoperability Program participant incentive payments, and EHR adoption.

2.1.1 Survey Results – EHR Adoption and Use, Health Information Exchange

This section contains information about surveys conducted over the years and provides the results.

2.1.1.1 2010 Environmental Scan

In 2010, the IME conducted provider surveys in collaboration with Iowa e-Health to understand the barriers and utilization of EHR in Iowa[5]. Surveys were developed and reviewed by e-Health workgroups and the IME staff. The IME promoted the surveys through meeting with professional organizations and utilizing our existing provider outreach processes. Additional provider types, including home health care, long term care, laboratories, and pharmacies were included in the surveys.

2.1.1.2 2015 Environmental Scan

IME conducted a second environmental scan in 2015[6] which shows how health IT adoption evolved over the five years between scans in the state of Iowa among Promoting Interoperability Program Eligible Providers, Eligible Hospitals, and Eligible Providers who are dentists; who had received at least one program incentive payment. The results provide general patterns and trends. The survey results provide insight to the IME on where providers and hospitals participating in the program show progress or lack thereof in the adoption and use of health information technology and health information exchange or interoperability.

2.1.1.3 2013 – 2018 Provider Enrollment HIT Survey Results

The IME's provider portal was enhanced in 2013 to survey providers regarding their EHR implementation and meaningful use status and future plans. This survey is collected as part of provider re-enrollment process cycle which is every five years. The HIT Provider Enrollment Survey allows Iowa to continue to monitor EHR adoption progress within the state on an ongoing basis, beyond those providers who are receiving incentives. Provider re-enrollment launched in May 2013. Results were calculated for the provider portal survey in July 2014.

- 16,114 providers responded to questions about EHRs and health information exchange as part of the re-enrollment process
- 83% responded that they currently used electronic health records

[5] More information regarding the 2010 assessment can be found here: http://ppc.uiowa.edu/health/study/e-health-baseline-assessment-health-information-technology-use-providers-iowa

[6] Information regarding the 2015 HIT Landscape can be found at http://ppc.uiowa.edu/publications/iowa-health-information-technology-and-meaningful-use-landscape-2015

- Providers that responded affirmatively to using an EHR, 91%, are using a certified EHR
- For those who responded that they didn't use an EHR, we asked if they had plans to purchase one. While just under half had plans to purchase an EHR in the next five years, 58% of providers responded that they did not have any plans to purchase an EHR.
- Responses to health information exchange connections include 34% of providers have no plans to exchange health information, 11% connected to IHIN, 17% will connect within 1 year, 16% will connect within 2-3 years

Provider re-enrollment, which began in November 2015 and continued throughout 2016, due to MCO implementation, once again included the EHR adoption survey as part of the process. The survey was updated to capture additional information. Results were captured and reported in February 2017, with the most recent results reported through December 2018.[7]

Key Outcomes:

- More than 70% of respondents use an EHR
- An average of 75% of respondents that currently have an EHR, use a CEHRT
- The majority of respondents who are using CEHRT reported using 2014 and 2015 versions of CEHRT. 7% or less of respondents use 2011 CEHRT.
- An average of greater than 70% of respondents participate in the Promoting Interoperability Program
- The majority of respondents are NOT connected with the Iowa Health Information Network (IHIN)
- Majority of respondents are NOT connected with any HIE
- An average of greater than 70% of respondents do not want to submit eCQMs to the IME

2.1.1.4 2017 Environmental Scan and Key Informant Interviews

In 2017 IHIN, through the HITECH IAPD, conducted an Environmental Scan Survey and Key Informant Interviews Qualitative scan. The surveys included the following provider types:

- Home Health Agencies
- Long Term and Post-Acute Providers
- Hospices
- Rural Health Clinics and Federally Qualified Health Centers
- Assisted Living

The objective of the survey was to determine the information technology capabilities and scope of electronic exchange of health information in the current state and within the next two years. Conclusions from the survey included:

[7] See https://dhs.iowa.gov/ime/providers/tools-trainings-and-services/medicaid-initiatives/EHRincentives for the Provider Enrollment survey results.

- A large proportion of the providers were already using an EHR
- Many providers were already engaging in some form of electronic information exchange, even if it was only with hospitals/providers within their own network/organization, and access was “read only”
- Four types of providers (not Assisted Living) reported a fair amount of data reporting and CQI, which requires collating and electronic submission of clinical information to regulators/payers
- Providers generally agreed that HIE would benefit their patients

Emerging themes from the Key Informant Interviews included:

- EHR adoption low in some settings
- Most data sharing between settings uses paper record transfer
- Large information system vendors are used by larger health systems, but electronic exchange outside of those systems is limited
- Portals are becoming the norm for view only data sharing
- Health information exchange concepts not well understood and in many cases misunderstood
- Even when information exchange capabilities exist they are seldom fully implemented, operationalized or generalized creating information silos
- Admission, discharge and transfer alerts are desired, however, when available are not well integrated into workflow
- Most care coordination services use manual work methods to accomplish broad responsibilities
- Significant number of organizations are participating in alternative payment models, but few have technical infrastructure needed to accomplish goals of accountable care
- Merit-based incentive Payment System (MIPS) / meaningful use (MU) attestation is a top priority for organizations

Recommendations included:

- Education and technical assistance relevant to care coordination, information exchange, and infrastructure needed for Alternative Payment Models which focus on capabilities to communicate, collaborate, and coordinate care.
- Process improvement activities to standardize workflows tailored to unique care settings, metrics, and dashboards for tracking progress and success
- Technology: identify funding or policy mechanism to drive adoption of EHRs in LTC setting, use-case driven roadmap strategy, CCD-A use needed for care coordination, and implement technology tools that support care coordination such as timely data streams, registries, tracking, monitoring, statistical risk-adjustment, and visualization dashboards

2.1.1.5 2017 SIM Current State of HIT in Iowa Report

Under the State Innovation Model Grant, the IDPH used survey report information above and the overview of HIT systems operating in the state inventory captured

under SIM to compile a summary report of the state of HIT in Iowa[8]. Summaries for the state of HIT in Iowa include financing, governance, and sustainability.

The following conclusion was drawn in the report:
Long term sustainability of health information technology and health information exchange will be made possible if ALL provider systems participate, if additional provider types (behavioral health, long-term care, pharmacy, etc.) connect to participate in exchange of information and if additional use cases can be identified to the benefit of the patient, provider and payer.

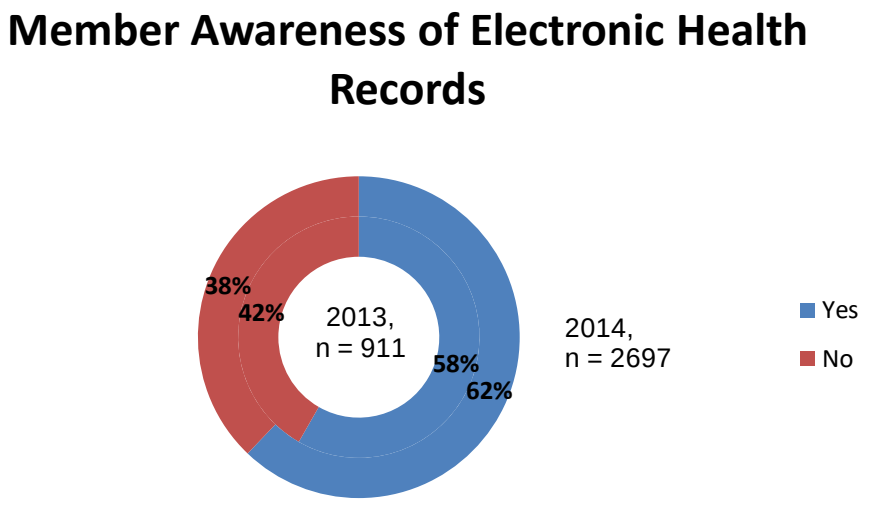
2.1.1.6 2020-2021

Between October 2020 and December 2021, a new environmental scan and key informant interviews will be planned, and conducted. The final report will include longitudinal information to assess the beginning through the end of the Medicaid Promoting Interoperability Program. The final report will be included in the final SMHP.

2.1.2 Survey Results – IME Member Services Survey

Iowa Medicaid began baselining member's knowledge of EHR/HIE technologies during July 2010. The latest survey results are from April 2014. When asked whether the respondent was aware of electronic health records, 62% said yes. The amount of members aware of electronic health records grow each year, as shown in the figure below.

Figure 1



[8]2017 IDPH The Current State of HIT in Iowa SIM Grant
https://idph.iowa.gov/Portals/1/userfiles/138/HIT%20Report%20FINAL.pdf

Respondents were asked whether they were in support of sharing EHRs between providers for their treatment. Most respondents were supportive 82% (n = 2,201), conversely, 18% (n = 473) of respondents were in opposition to the use of EHRs for their treatment. To gauge the likelihood of members who would view their own health records on the internet, members were asked if Iowa Medicaid made it available would the member use it. About 69% (n = 1,824) of respondents report that they would view their own health records if available, 31% (n = 817) stated that they would not.

2.1.3 Iowa Medicaid Promoting Interoperability Program Provider Targets & Attestation

At the beginning of the program the IME informally estimated that approximately 10% of Eligible Professionals would meet the Medicaid encounter requirements. The IME determined a rough order of magnitude estimate that approximately 1,200 eligible providers would meet the Medicaid encounter requirements. The rough order of magnitude was assumed accurate within a range of -50% to +200%. The IME estimated that 90% of hospitals would be eligible for the program, or 105 hospitals.

The IME Promoting Interoperability Team performs outreach to Eligible Providers and Hospitals to attest to the Promoting Interoperability Program primarily through email and direct phone calls. A specific outreach program for dentists was implemented in 2016, including a webinar series to assist dentists in moving onto meaningful use of the EHR. The dedicated DHS HIT & PI Program website is kept up to date as program requirements and tools change. As 2016 was the last chance for providers to initiate participation in the program, there was a significant amount of outreach performed to assist providers and hospitals who had not yet entered the program. The IME has achieved the following unique number of EPs and EHs into the Promoting Interoperability Program as of 2016. The IME exceeded the original provider estimated target by 168% and the hospital target by 105%.

Figure 2 Unique Attestations

Program Year	EP	EH	Total Unique Attestations Per Year
2011	775	50	825
2012	415	43	458
2013	234	5	239
2014	218	2	220
2015	177	0	177
2016	200	11	211
Totals	**2019**	**111**	**2130**

The IME continues its efforts to assist providers through each year and stage of the program

Figure 3 Eligible Provider PI Program Return Rate

Provider Type	Provider Count (Pay Year 1)	Provider Count (Pay Year 2)	% Pay Year 2 / Pay Year 1 Return Rate	Provider Count (Pay Year 3)	% Pay Year 3 / Pay Year 2 Return Rate	Provider Count (Pay Year 4)	% Pay Year 4 / Pay Year 3 Return Rate	Provider Count (Pay Year 5)	% Pay Year 5 / Pay Year 4 Return Rate	Provider Count (Pay Year 6)	% Pay Year 6 / Pay Year 5 Return Rate
Certified Nurse - Midwife	38	23	60.53%	19	82.61%	13	68.42%	7	53.85%	3	42.86%
Dentist	266	8	3.01%	4	50.00%	2	50.00%	1	50.00%	0	0.00%
Doctor of Optometry	2	0	0.00%								
Nurse Practitioner	475	296	62.32%	203	68.58%	137	67.49%	81	59.12%	54	66.67%
Physician	1,119	728	65.06%	554	76.10%	471	85.02%	333	70.70%	237	71.17%
Physicians Assistant practicing in FQHC or RHC led by a PA	22	17	77.27%	13	76.47%	10	76.92%	8	80.00%	6	75.00%
Totals for All Providers	**1922**	**1072**	**55.78%**	**793**	**73.97%**	**633**	**79.82%**	**430**	**67.93%**	**300**	**69.77%**

The IME predicts that the following number of providers will return for Program Years 2020, and 2021; the remaining years of the program:

Figure 4 Predicted # EP Attestations

Program Year	Predicted # EP Attestations
2020	150
2021	100

The IME Promoting Interoperability Program team will continue its outreach efforts to encourage EPs to return and attest to the program. The outreach will aim to assist providers in overcoming barriers to successfully attest and receive an incentive payment, and hope to surpass the number of predicted attestations in remaining program years.

The breakdown of the number of AIU and MU counts and payments per year can be seen in figure 5, while figure 6 illustrates the dollar amount of incentives by provider type for adopting, implementing or upgrading to CEHRT and for Meaningful Use. Please note program year 2020 is still in progress, while all other program years have closed.

Figure 5 Medicaid incentive payment for AIU and MU

	EP				EH			
	AIU		MU		AIU		MU	
	Count	Amount	Count	Amount	Count	Amount	Count	Amount
2011	775	$16,227,928	0	$0	50	$18,100,832	0	$0
2012	412	$8,577,923	489	$3,955,341	38	$8,040,791	42	$14,095,764
2013	229	$4,823,751	572	$4,789,758	4	$715,043	82	$15,924,567
2014	121	$2,394,167	623	$5,564,674	0	$0	61	$9,713,125
2015	155	$3,244,167	519	$4,505,010	0	$0	17	$2,227,342
2016	175	$3,662,084	541	$4,684,922	0	$0	15	$2,570,512
2017			295	$2,473,504			11	$2,255,941
2018			177	$1,493,168			11	$1,127,971
2019			65	$552,490				
2020			1	$8,500				

Figure 6 Payments by provider type

	AIU TOTAL		MU TOTAL	
Provider Type	Count	Payment	Count	Payment
Physician	1084	$22,418,770	2357	$20,019,993
Pediatrician	168	$3,102,520	823	$6,662,627
Nurse Practitioner	456	$9,562,500	793	$6,893,500
Certified Nurse - Midwife	38	$807,500	63	$535,500
Dentist	266	$5,652,500	15	$127,500
Physicians Assistant practicing in FQHC or RHC led by a PA	22	$467,500	54	$450,500
Hospital *Hospital payments are rounded to nearest dollar	92	$26,856,667	239	$47,915,223

The IME chose to break out hospital incentive payments to the minimum allowed number of payments, three, and paid the incentives at a 40/40/20 split across the three years. There are six hospitals which did not participate in the Medicaid Promoting Interoperability Program. All but two hospitals who entered the program received all three years of incentive payments.

Figure 7 Hospital Participation

Hospitals	
0 Medicaid Payments Received	6
1 Medicaid Payment Received	111
2 Medicaid Payments Received	111
3 Medicaid Payments Received	109

The maps below show payments made to providers and hospitals across the State of Iowa as of July 2019. Hospital payments are complete, and no more payments will be made within the program.

Figure 8: Map of Medicaid Eligible Provider EHR Incentive Payments by County

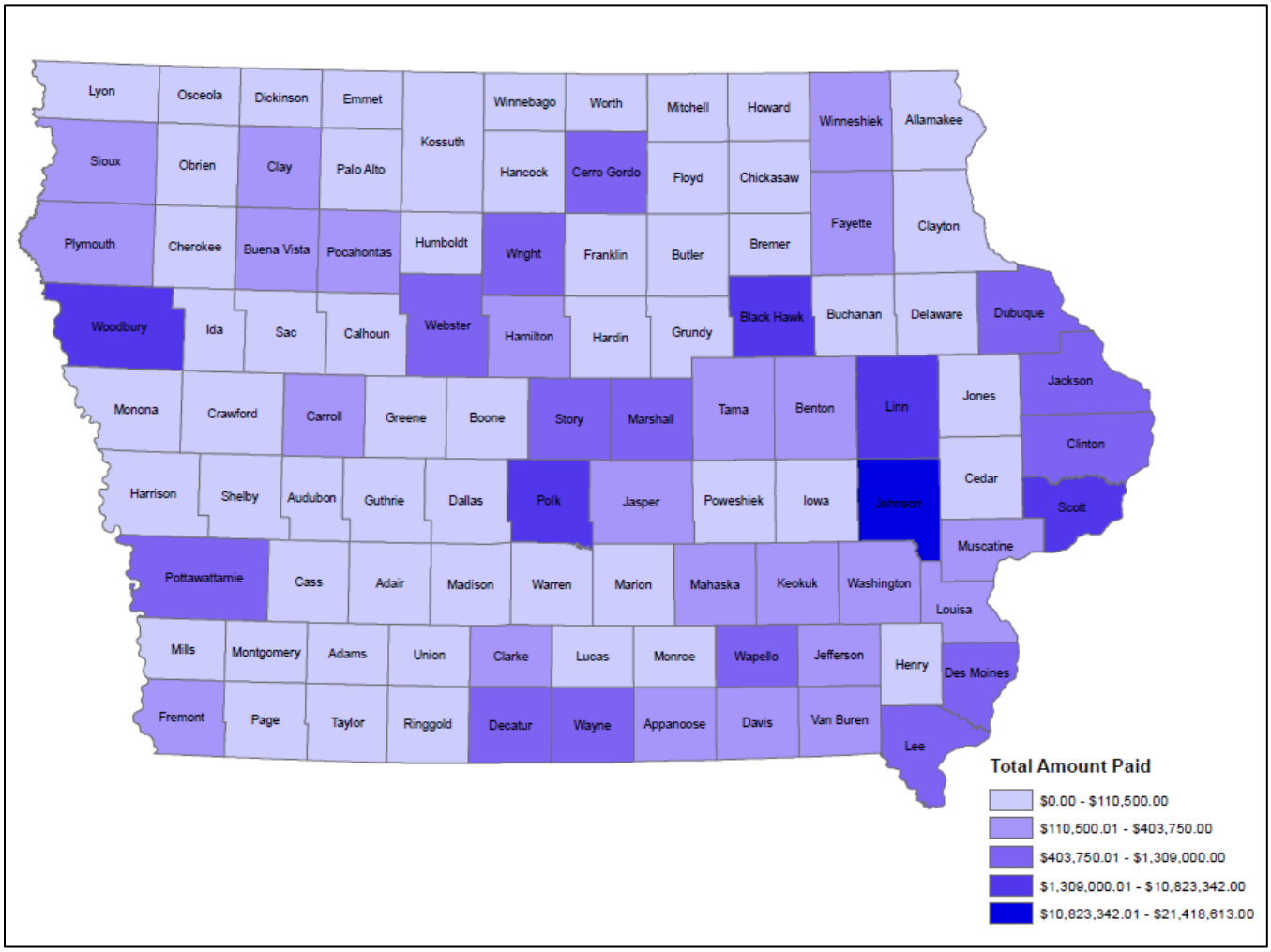
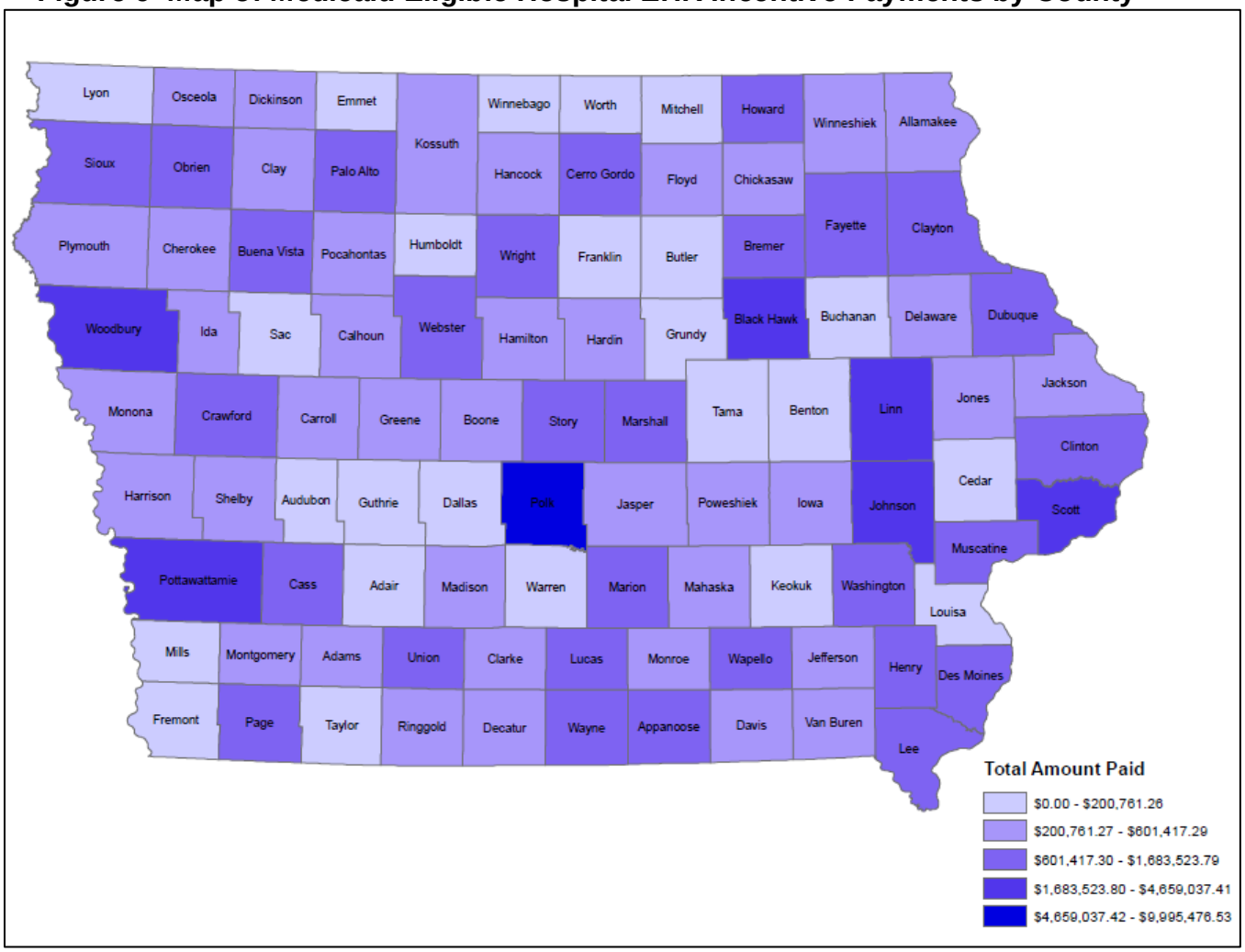


Figure 9 Map of Medicaid Eligible Hospital EHR Incentive Payments by County



2.1.4 CEHRT Used in Iowa

Providers have attested to the Iowa Medicaid Promoting Interoperability Program with the following CEHRTs:

Table 1 CEHRT Used in the Iowa Medicaid Promoting Interoperability Program

CEHRT	Count of Unique Providers Attested to Using CEHRT
Abraxas Medical Solutions, Inc.	1
AdvancedMD	3
AllMeds, Inc.	1
Allscripts	156
Amazing Charts	19
American Medical Software	3
Anasazi Software Inc.	22
Aprima Medical Software, Inc.	83
athensahealth	16
Bizmatics Inc.	1
CareCloud Corporation	1
Cerner	40
Compulink Healthcare Solutions	5
Connexin Software, Inc.	2
CPSI	11
Credible Behavioral Health	12
Defran Systems, Inc.	1
DentiMax, LLC	1
digiChart, Inc.	3
DrFirst	1
eClinicalWorks, LLC	15
Emdeon Corporation	5
eMDs	18
Epic	777
Exam Enterprises	90
Eyefinity, Inc.	1
GE Healthcare	190
Greenway	93
HealthFusion	6
Henry Schein Practice Solutions, Inc.	39
Integrity EMR, LLC	1
LSS Data Systems	29
Lumeris Solutions LLC	1
MacPractice, Inc.	2

McKesson	14
MDoffice LLC	1
MED3000, Inc	1
Medflow Holdings, LLC	1
MEDITECH	76
Mediture LLC	7
MedPlus, A Quest Diagnostic Company	1
Mitochon Systems, Inc.	39
Netsmart Technologies	7
nextEMR, LLC	4
NextGen Healthcare	100
Office Ally, Inc.	1
Patterson Dental Supply, Inc.	8
Planet DDS, Inc.	2
Practice Fusion	40
PracticeSuite, Inc.	1
Practice-Web Inc.	1
Professional Economics Bureau of America, Inc.	8
QueenCity Code Factory	1
Remarkable Health, LLC	4
Sage	2
Seven Software, LLC	13
SuccessEHS	17
U.S. HealthRecord, Inc.	3
Valant Medical Solutions, Inc.	1
Vitera Healthcare Solutions, LLC	10
Wellcentive, Inc.	4

2.2 Broadband Access

Iowa continues to have challenges with broadband access. Iowa senators sent a letter[9] to the FCC in July 2019 requesting that broadband maps be produced at a more granular level so access to federal funding can be realized. The letter requests the FCC's maps be improved so public and private partners have access to accurate data and to ensure access to funding for rural communities.

2.2.1 Broadband and the Office of the Chief Information Officer (OCIO)

The State of Iowa Office of the Chief Information Officer administers broadband programs[10] designed to increase access to high-speed Internet services in underserved and unserved areas of the State of Iowa. Three main programs are coordinated by the Office to support broadband initiatives:

[9] https://www.grassley.senate.gov/sites/default/files/constituents/CEG%20JKE%20broadband%20letter.pdf
[10] Information regarding Iowa's OCIO and broadbrand, including maps: https://ocio.iowa.gov/broadband

- Broadband Grants Program
- Broadband Property Tax Exemption Certification
- Broadband Map

Iowa Broadband Maps
The OCIO maintains the State of Iowa Broadband Availability map. The map identifies locations and availability of broadband service in the State of Iowa.[11] The OCIO also maintains a broadband mapping archive.[12]

2.2.2 Iowa HF772 - Empower Rural Iowa Act

The Empower Rural Iowa Act provides incentives for Broadband and workforce housing. It was signed into law May 2019.

The OCIO administers a broadband grant program designed to reduce or eliminate unserved and underserved areas in the state, leveraging federal funds and public and private partnerships where possible, by awarding grants to communications service providers that reduce or eliminate targeted service areas by installing broadband infrastructure that facilitates broadband service in targeted service areas at or above the download and upload speeds specified in the definition of targeted service area.

The broadband infrastructure grant program is authorized in Iowa Code section 8B.11. Grants are awarded to communications service providers on a competitive basis. More information regarding the grant program can be found on the OCIO webpage.[13]

2.2.3 Broadband Grants

Table 2 Iowa has received the following grant awards as posted on the NTIA's BroadbandUSA website[14]

Grantee	Total Award	Type	Project Serves	Award
Central Iowa Hospital Corporation, d/b/a Iowa Health-Des Moines	$8,321,815	Sustainable Adoption	Iowa	2010-2013
Communication Service for the Deaf, Inc.	$14,988,657	Sustainable Adoption	Multiple States including Iowa	2010-2013
Connected Nation (Iowa)	$5,769,942	Broadband Data & Development	Iowa	2010-2014

[11] DRAFT 2020 State of Iowa Broadband Availability Map https://ocio.iowa.gov/draft-2020-state-iowa-broadband-availability-map
[12] Broadband Mapping Archive https://ocio.iowa.gov/broadband-mapping-archive
[13] Empower Iowa Rural Iowa Broadband Grant program https://ocio.iowa.gov/broadband-grants
[14] More information regarding NTIA's BroadbandUSA grants: https://www2.ntia.doc.gov/iowa

Iowa Communications Network	$16,230,118	Infrastructure	Iowa	2010-2013
Iowa Health System	$17,714,919	Infrastructure	Iowa	2010-2013
University Corporation for Advanced Internet Development	$62,540,162	Infrastructure	Multiple States including Iowa	2010-2013

Table 3 FCC Broadband Grant Awards as posted on the website[15]

FCC Auction 903 Connect America Fund Phase II	$5,428,772	Iowa	August 2018

USDA Broadband ReConnect Loan and Grant Program[16]

In March 2018, Congress provided $600 million to USDA to expand broadband infrastructure and services in rural America. On December 12, 2019, U.S. Secretary of Agriculture announced the availability of a second round of funding under the ReConnect Program. The ReConnect Program offers unique federal financing and funding options in the form of loans, grants, and loan/grant combinations to facilitate broadband deployment in areas of rural America that don't currently have sufficient access to broadband, defined by the law as 10 Mbps (megabits per second) downstream and 1 Mbps upstream. This program will generate private sector investment to deploy broadband infrastructure to provide high-speed internet e-Connectivity to as many rural premises as possible, including homes, community facilities for healthcare and public safety, schools, libraries, farms, ranches, factories, and other production sites.

Award announcements information can be found on the USDA Announcements webpage.[17] Iowa counties mentioned in the award announcements include Mitchell, Cherokee, Wapello, Howard, Chickasaw, Taylor, Page, Appanoose, Davis, Iowa, Johnson, Arcadia, and Carroll. There are also mentions of awards in southern and northern Iowa.

2.2.4 BroadbandNow

BroadbandNow is a website built to assist consumers find and compare Internet service providers in their area. BroadbandNow takes multiple data sets and combines them together to build a public Internet service database online. BroadbandNow provides maps with Iowa data and statistics on their website.[18]

[15] FCC Auction 903 Connect America Fund Phase II: Assignments - Winning Bidders https://auctiondata.fcc.gov/public/projects/auction903/reports/winning_bidders or https://auctiondata.fcc.gov/public/projects/auction903/reports/total_assigned_by_state

[16] More information on USDA ReConnect Loan and Grant Program https://www.usda.gov/reconnect

[17] USDA Reconnect Announcements https://www.usda.gov/reconnect/announcements

[18] BroadbandNow Iowa information https://broadbandnow.com/Iowa

2.2.5 Connected Nation Iowa[19]

Connected Nation Iowa is a subsidiary of Connected Nation and operates as a non-profit in the state of Iowa. CN Iowa partnered with the Iowa Public Service Commission to engage in a comprehensive broadband planning and technology initiative as part of a national effort to map and expand broadband. The program began by gathering provider data to form a statewide broadband map and performing statewide business and residential technology assessments but has since progressed to working with communities on community plans. Bolstered by benchmarking data that has been gathered through Connected Nation's mapping and market research, the Connected Community Engagement Program (Connected[SM]) is drilling down to the regional and local level to facilitate community technology planning. CN Iowa **maps** are available on the website.[20]

2.2.6 Iowa Communications Network (ICN)[21]

The Iowa Communications Network (ICN) provides high-speed flexible broadband Internet, data, video, voice (phone), and security services to authorized users, under Code of Iowa, which includes: K-12 schools, higher education, hospitals and clinics, state and federal government, National Guard armories, and libraries. The ICN's **strategic plan** is posted on the website for 2018-2022.[22]

2.3 Federally Qualified Health Centers

There are 14 FQHC's in the state of Iowa, of which, 14 have attested and received incentive payments for the Promoting Interoperability Program. 12 FQHCs have received incentives for Adopt, Implement, Upgrade (AIU) and Meaningful Use; and 2 have received incentives for AIU only.

Iowa Primary Care Association[23], received an EMR implementation grant from Health Resource and Services Administration (HRSA). The grant totaled over $1.3 million. The $1.3 million grant and a variety of other funding sources helped to fund implementation of GE Centricity EMR in six Federally Qualified Health Centers (FQHCs) in Iowa and one in Nebraska. Next Gen and EHS EHR systems were selected for implementation within other individual FQHC locations. The grant's project period was September 1, 2009 – August 31, 2012.

FQHCs that participated in the Grant include:

- Primary Health Care, Des Moines and Marshalltown
- Peoples Community Health Clinic, Waterloo and Clarksville
- Crescent Community Health Center, Dubuque
- Community Health Center of Fort Dodge, Fort Dodge
- River Hills Community Health Center, Ottumwa, Richland, and Centerville

[19] Connected Nation Iowa https://connectednation.org/iowa/about/
[20] Connected Nation Iowa maps https://connectednation.org/iowa/state-mapping/
[21] Iowa Communications Network https://www.icn.iowa.gov/
[22] ICN's strategic plan https://icn.iowa.gov/about/agency-reports
[23] For more information about Iowa Primary Care Association https://www.iowapca.org/

- Siouxland Community Health Center, Sioux City

2.4 Veterans Administration & Indian Health Services

Within Iowa, the Veterans Health Administration (VHA) has Medical Centers in Des Moines and Iowa City, and 14 Community Based Outpatient Clinics. Every location is connected within the VA's infrastructure using VistA and Computerized Patient Record System (CPRS) to share clinical information both within state VA locations, and worldwide within the VA's infrastructure.

Iowa has one Indian Health Service facility within the state; the Meskwaki Tribe. The Meskwaki tribe has actively participated in the Iowa Medicaid Promoting Interoperability Program. They use the NextGen EHR certified to the 2015 edition, and NextGen Share for their HIE.

2.5 Health Information Technology and Health Information Exchange

This section includes and describes the following topics:

- Stakeholder Engagement and Relationships in HIT/E (governance, fiscal, geographic scope, etc.)
- HIT/HIE organizations, activities, and adoption within the state and surrounding state borders
- Role and relationships of the SMA and MES with HIT/HIE
- Use of the MU capabilities/HITECH systems to achieve state health goals
- Projected Medicaid Provider targets relating to health information exchange onboarding activities
- Providers' use of EHRs for other purposes
- Recent state law or regulation changes impacting the Promoting Interoperability Program or interoperability in general at the state level

2.5.1 Iowa Health Information Network (IHIN)

Iowa has had one state-wide designated health information exchange, called the Iowa Health Information Network, or IHIN. The IHIN has resided under two different models as described below.

2.5.1.1 Government-led Model

The previous governance model (2008 – March 31, 2017) was part of the Iowa e-Health initiative, and is best described as a government-led model with accountability to a multi-stakeholder, public-private e-Health Executive Committee and Advisory Council. The governance structure was established by a comprehensive health reform bill (HF 2539[24], 2008 Iowa Acts, Chapter 1188). Under this model, the IHIN resided within the Iowa Department of Public Health (IDPH). The legislation specified nine organizations be represented on the Executive Committee and eight organizations represented on the Advisory Council. Additional members of the

[24] House File 2539 https://www.legis.iowa.gov/legislation/BillBook?ga=82&ba=HF2539

Advisory Council were appointed by the Director of the Iowa Department of Public Health.

The nine voting members of the Executive Committee included: three chief information officers from the three largest private health care systems in the state; the chief information officer of the University of Iowa Hospitals and Clinics; a representative from a rural hospital selected by Iowa Hospital Association; a consumer member of the State Board of Health; a licensed practicing physician selected by the Iowa Medical Society; a licensed and practicing nurse selected by the Iowa Nurses Association; and an insurance carrier selected by the Federation of Iowa Insurers.

The IME and IDPH, as part of the Iowa e-Health EHR/IHIN adoption initiative, actively engaged Iowa's healthcare providers, insured citizens, and insurers. Due to the IME's expected use of IHIN services and expected funding of IHIN activities, the IME provided a strong presence on many of the e-Health workgroups and council sessions. The IME's focus within the workgroups was containing costs by improving the quality of care our members receive.

2.5.1.2 Non-Profit Entity Model

The IHIN governance model through Iowa Code 135D[25] was enacted March 31, 2017; which specifies that the IHIN non-profit designated entity is governed by a board of directors. The legislation specifies the board composition which includes the Iowa Medicaid Director, or designee; and Director of Public Health, or designee; one member who is a consumer of health services; and a majority of the voting members of the board shall be representative of participants in the Iowa health information network. The board of directors appoint a CEO to manage the daily affairs of the IHIN.

2.5.2 IHIN Operations under IDPH

Iowa e-Health issued a Request for Proposal for the creation of Iowa's statewide HIE, or IHIN. The IDPH issued a Notice of Intent to Award and executed the contract to the selected vendor. The IDPH installed the IHIN infrastructure and began engaging in implementations.

The following provides a brief retrospective of the legislative and administrative history leading up to the transition of the IHIN on March 31, 2017 to the new non-profit designated entity.

2.5.2.1 The Beginning

- 2008 Iowa Acts, Chapter 1188 Section 25 created the Iowa e-Health Executive Committee, Advisory Council and work groups, to be led by the Iowa Department of Public Health.

[25] Iowa Code 135D https://www.legis.iowa.gov/docs/code/135d.pdf

    - Tasked with investigating and making recommendations regarding health information technology, setting standards, ensuring privacy and security, identifying funding options, etc.
    - Responsible to create a state plan for health information technology and exchange for the state.
- February 2009 President Obama signed the American Recovery and Reinvestment Act, providing $19 Billion in funding for Health Information Technology implementation throughout the country.
- 2009 was the first meeting of the Iowa e-Health Advisory Council.
- 2010 Strategic and Operational Plan was submitted as a required deliverable of the State HIE Cooperative Agreement. This allowed the state to access $8,375,000 for planning and implementation of the HIE from 2010-2014.
- Summer of 2010 the RFP to build a statewide HIE was released.
- ACS/Xerox awarded the contract with Informatics Corporation of America (ICA) as the technology subcontractor.

2.5.2.2 The Middle Years

- 2012 Legislation Iowa Code Sections 135.154-135.156F provided the framework to implement and operate a statewide health information exchange. Some key points:
- Established the State Board of Health as the governing body of the IHIN.
- Directed the work of the Department.
- Established the IHIN fund and mechanism for the Department to charge and collect Participant fees.
- Established Iowa as an opt out state in regards to patient choice in participation in the IHIN.
- Restricted the IHIN from creating or utilizing a repository model for exchange.
- Directed the Department and Executive Committee to review the governance structure in the final year of the Cooperative Agreement and provide recommendations to the legislature regarding future governance of the IHIN.
- Service offerings of the IHIN were identified, built and marketed and fees established.
- Privacy and Security Policies were implemented.
- Administrative Rules were developed and implemented.
- Early adopters of the IHIN were connected for Direct Secure Messaging and Electronic Lab Reporting.
- Query Exchange connections were made.
- Xerox chose to leave the HIE space in Iowa in 2014 and the contract was assigned directly to ICA.
- Iowa Medicaid was awarded a State Innovative Model grant and partnered with the Department and IHIN to facilitate the creation of the SWAN, alerting providers should a patient arrive in the ER, be admitted or discharged from a hospital.

2.5.2.3 The Transition

- 2015 HF 381 directed the Department to engage in a competitive RFP process to transition the IHIN out of a state government led model of governance to a private non-profit company.
- In the summer of 2015 an RFI was released to measure interest in acquisition of the IHIN. Five organizations responded to the RFI.
- In summer of 2016 the RFP was released. There was one respondent.
- In December 2016 the Department issued a notice of intended selection of a designated entity for Hielix/Koble Group (HKG).
- March 31, 2017 the agreement was signed and the non-profit IHIN was created.
- The fund balance was transferred with the IHIN.
- All existing contracts and Participation Agreements were assigned and obligated to the new non-profit IHIN.
- Code sections 135.154-135.156F were repealed and Iowa Code sections 135D.1-135D.7 took effect.
- Iowa continues as an opt-out state.
- Requires the Board of Directors to be representative of Participants and assigns the Directors of the Department of Public Health and Iowa Medicaid to be members.
- Required the IHIN to be a non-profit company.
- Provides for some ongoing reporting requirements to the state.

2.5.2.4 The Final Numbers

- Service Offerings:
    - Direct Secure Messaging, HISP Services, XDR Services
    - Query Exchange
    - Electronic Lab Reporting
    - Cancer Registry
    - Statewide Alert Network (SWAN) for Medicaid ACOs and MCOs
- 170 total Participants
    - 117 Hospitals
    - 368 Ambulatory Practices
    - 16 Local Public Health
    - 17 Long Term Care
    - 166 Specialty Practices
    - 75 Other

2.5.2.5 IME's Participation and Engagement with the IHIN under IDPH

The IME provided support through HITECH IAPD funding requests to develop the IHIN platform and public health registries for the Promoting Interoperability Program. IME's portion of the platform build was cost-allocated during this timeframe. When the requested funding ended, IME began participating with the IHIN through the IHIN Participation Agreement July 1, 2016.

Legislation, HF381, was put into place in early 2015 which allows for treatment, payment, and operations use of the record locator service, or query. The IME was approved for query access with the IHIN on August 7, 2015. The Medical Services unit piloted the use of query in workflows, however, the information sought did not return useful results. Several dental provider organizations used Direct Secure Messaging for Prior Authorization communication with the IME.

Figure 10 IHIN under IDPH Timeline of Major Events

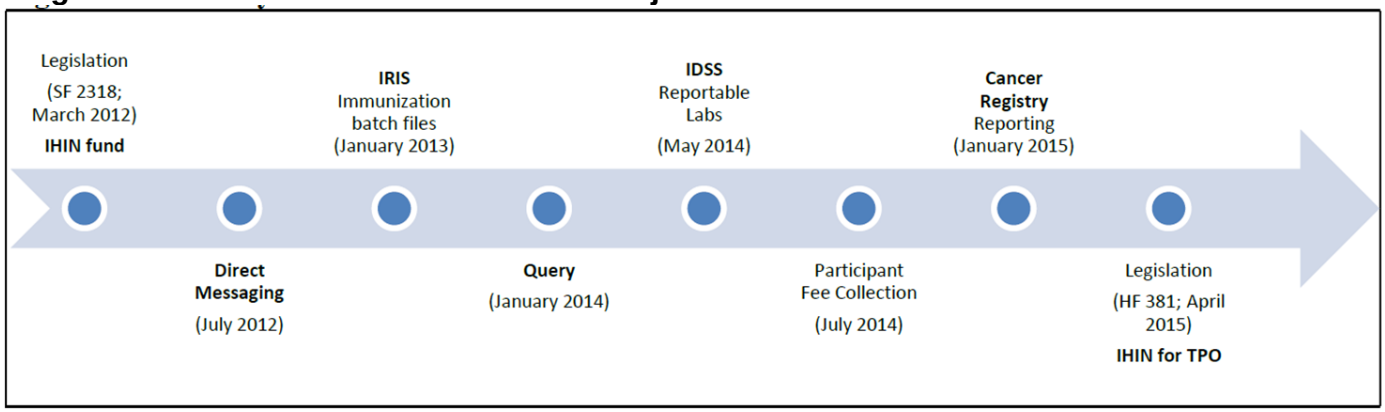


Figure 11 IHIN Services Offered under IDPH from 2012 through March 31, 2017

IHIN Iowa Health Information Network

Iowa Health Information Network (IHIN) Services Summary

What is IHIN?

The IHIN is a "hub" that facilitates the sharing of patient health information between authorized participants. The IHIN is not a central repository; rather patient health information is stored at the provider location.

Current IHIN Services

- ***Direct connections to Electronic Health Records (EHRs):*** Ability to seamlessly access information available through the IHIN within a provider EHR.
- ***IHIN Portal:*** Secure internet-based portal that allows participants to access information available through the IHIN.
- ***Direct secure messaging:*** Ability to send and receive secure messages between providers using the IHIN portal.
- ***Health Information Service Provider (HISP) services:*** Ability to use IHIN as the HISP for Direct through EHR for HISP agnostic systems. (EPIC & Meditech)
- ***Cancer registry reporting:*** Ability to electronically report cancer data to the State Health Registry of Iowa (SHRI)
- ***Electronic reporting of reportable diseases:*** Ability to report required laboratory results for reportable diseases or conditions to public health.

In Development

As IHIN develops and funding is available, Iowa e-Health is adding additional services. Below is a list of services that are in development. Cost and additional participation fees have not been established for these services.

- ***HealtheWay connectivity:*** Ability to communicate nationally with Social Security Administration, Department of Defense, Veterans Affairs, Centers for Disease Control, and other statewide health information exchanges.
- ***Alerting System:*** Ability to create alerts for care teams using ADT feeds from hospitals. Supported by the IME SIM grant.

Future Services

As IHIN develops and funding is available, Iowa e-Health may add additional services. Below is a list of potential services that have been considered. Cost and additional participation fees have not been established for these services.

- ***IRIS Data:*** Ability to pull an immunization history through IHIN from IRIS.
- ***Medication Reconciliation:*** Ability to do a medication reconciliation using provider and pharmacy

2.5.3 IHIN Non-Profit Entity

2.5.3.1 Vision and Mission

The vision of the IHIN is "One Connection." IHIN's mission is to provide all entities in the Iowa healthcare ecosystem with connectivity to the Iowa Health Information Network to enable the secure exchange of patient and other healthcare related information.

2.5.3.2 Governance Structure

A board of directors governs and administers the IHIN under Iowa Code 135D which details the consistency of board members:

- Consumer of health services
- Director of Public Health (or designee)
- Director of Iowa Medicaid Enterprise (or designee)
- Majority of the voting members of the board shall be representative of participants in the IHIN
- Commissioner of insurance acts as an ex officio, nonvoting member

Per Iowa Code 135D[26]:

- The Board of Directors appoint a CEO to manage the daily affairs of the IHIN, which includes: ensure that the designated entity enters into contracts with each state agency necessary for state reporting requirements.
- The IHIN is directed to operate in an entrepreneurial and businesslike manner in which it is accountable to all participants utilizing the network's products and services.
- The IHIN designated entity is not considered, in whole or in part, an agency, department, or administrative unit of the state, nor is it required to comply with any requirements that apply to a state agency, department, or administrative unit and shall not exercise any sovereign power of the state.
- The state shall not guarantee any obligation of or have any obligation to the designated entity.

2.5.3.3 Platform Transition

As the non-profit entity was established, the CEO worked with the IME to request HITECH 90/10 funding to support a phased approach to plan, build, and onboard to the IHIN.

During 2017, the IHIN conducted surveys and formed a technical workgroup to solicit requirements gathering of what participants would want in the new platform, what was important, nice to have, etc. The technical workgroup team met over the summer months. The IHIN team decided that there were just a few viable options for HIE vendors in the market, and invited several to respond to the limited RFP. (This was

[26] See Iowa Code 135D for more information https://www.legis.iowa.gov/docs/code/135d.pdf

the nonprofit IHIN's RFP and RFP process – see Iowa Code 135D for further information.)

Phase I - Planning

- HIT Environmental Scan of certain provider types & Key Informant Interviews were conducted
- Requirements gathering session was held in Technical Workgroup meetings
- New platform vendor selection process, and contract with new vendor occurred
- October 2017 new HIE platform vendor selected (Orion)
- February 2018 – the IHIN went on a "roadshow" to several cities across Iowa to promote the IHIN and new platform.
    - The IHIN CEO met with stakeholders such as WellMark Blue Cross & Blue Shield, Iowa Hospital Association, University of Iowa Hospitals & Clinics, the SIM C3s, and other healthcare leaders

As part of IHIN's Phase I planning, the IHIN established Key Roadmap Targets:

Figure 12 IHIN's Key Roadmap Targets

Phase II – Design, Development, and Implementation

- March 2018 - New IAPD requests for HIE activities were approved by CMS.
    - Activity Requests included:
        - Platform Onboarding
        - Provider Onboarding
        - Public Health Specialized Registries
        - Additional HIE Services

- Onboarding IHIN participants to Orion platform begins
- HIE Services disabled with former HIE platform vendor (ICA)

At the end of May 2018, there was a change in IHIN leadership. The IHIN continues to operate and enhance functionality and offerings to modernize and improve services to support Medicaid providers' abilities to reach MU measures. The IHIN intends to make several enhancements to the professional services offerings and will be designed to improve providers' and hospitals' abilities to enhance care coordination, transitions of care, and population health strategies in Iowa. These services and milestones include the following:

- Continue to Expand Provider and Patient Connectivity
- Improve IHIN Capabilities
- Interstate Exchange
- Continue Building Upon Sustainability Model
- Connect Public Health Registries
- Enhanced Alert Capabilities
- Support Governor's Round table recommendations
- Connecting all healthcare entities in the Iowa healthcare ecosystem to IHIN
- Expanding notifications and alerts by including admission, discharge, transfer (ADT) message feeds from all entities in the Iowa healthcare ecosystem to IHIN
- CCD-A exchange capabilities

2.5.3.4 Onboarding Activities

As of September 2019, IHIN has 122 active Participation Agreements covering 660 sites. Onboarding activities during 2018 and 2019 have included:

- VPN connections to the Orion Platform
- Interface connections including ADT, CCD, ORU, and MDM
- Direct connections (XDR HISP and Portal)
- Public Health Registry connections including Electronic Lab Reporting, Newborn Screening, and Cancer

Other IHIN development and implementation activities included modifying the Orion platform to provide both a centralized and federated model options. The platform build was completed during the Phase II project. The Phase II project work ended September 30, 2019.

2.5.3.5 IME's Participation and Engagement with IHIN under the Non-Profit Designated Entity

Per Iowa Code 135D, the Iowa Medicaid Enterprise Director, or designee, is a voting member of the IHIN board of directors; and attends board meetings. Some of the IHIN board meetings are open to non-board members, and the IME's HIT Coordinator attends these meeting occurrences.

Shortly after the IHIN transitioned to the non-profit structure, the IHIN formed a Technical Workgroup to develop requirements of what Iowa providers wanted in an

HIE platform. The workgroup consisted of resources from some of Iowa's large health organizations, IDPH, and the IME.

The IME used part of its IHIN participation fee to support planning activities; which included a HIT Environmental Scan Survey[27] and Informational Interviews (see "Survey Results" in section 2.1). Once the planning activities were complete and the Technical Workgroup developed requirements which discovered that a more robust and capable centralized platform model was needed for broad health information exchange, IME worked with the IHIN and IDPH on a HITECH IAPD update to include public health registries which directly support meaningful use objectives, as well as provider onboarding activities, and the transition to a new platform. Activities are found under Phase I and Phase II above. During the project phases, IME held monthly status meetings with the IHIN and IDPH. The Phase II project work ended September 30, 2019.

2.5.4 Governor's Healthcare Innovation and Visioning Roundtable

At the same time the IHIN Orion Health platform was being implemented, and the IHIN's leadership was changing; Governor Reynolds appointed membership to the Healthcare Innovation and Visioning Roundtable[28]. This is a group of high level healthcare and business executives in Iowa working to build consensus and drive transformation of healthcare delivery in Iowa. Two workgroups were formed; the Healthy Communities Workgroup and the Sharing and Use of Data Workgroup, which met over the summer months of 2018. During the workgroup meetings, conversation brought to light that a centralized IHIN model in Iowa was not wholly desired by many participants of the workgroup, and that a federated option should be offered. The Governor's Roundtable continues efforts to mature the Use and Sharing of Data within Iowa through the recommendations.

The Governor's Healthcare Innovation and Visioning Round Table brings together influential business leaders, payers, providers, and public agency leaders. The Roundtable continues to engage stakeholders and form an overall statewide strategy for Healthy Communities and Use and Sharing of Data. Through these initiatives a governance model and health information exchange will be more broadly realized and specific data sharing use cases detailing the where and how will be discovered. The recommended key strategies approved by Governor Reynolds include:

Recommendations to Achieve Sustainable Healthcare Transformation

- State and Community Engagement Strategy
- High Need, High Cost Identification Strategy
- Social Supports Strategy
- Payment and Payer Strategy

[27] IHIN 2017 Environmental Scan Survey Results https://www.ihin.org/article/ihin-2017-environmental-scan-survey-results

[28] Governor's Healthcare Innovation and Visioning Roundtable: https://dhs.iowa.gov/ime/about/initiatives/newSIMhome/roundtable.

Enabling the Transformation of the Delivery and Payment of Care through Technology

- Real Time Healthcare Information Strategy
- Data Privacy Strategy
- Oversight Strategy

Ensuring Sustainability of Strategies to Improve the Lives of All Iowans

- Sustainability Strategy
- Convening Strategy
- Stakeholder Engagement Strategy
- Evaluation Strategy

The revitalized engagement of various stakeholders in HIT and health information exchange from meetings of the Governor's Healthcare Innovation and Visioning Roundtable will assist participants in the Promoting Interoperability Program and guide opportunities for broader health information capture and exchange. One such example of providers' use of EHRs for other purposes is the use of standardized notifications at the point of service per the Roundtable's recommendation.

2.5.5 State Laws or Regulations Impacting Promoting Interoperability Program

A bill, HF2377[29] referred to as the opioid bill, was passed into law May 2018. An interoperability win is the electronic reporting to the PMP within 24 hours of prescribing a controlled substance, and electronic reporting of all prescribed substances beginning in January 2020. A summary of the bill follows:

- Adds naloxone administrations by first responders and dispensings by pharmacies as reportable to the PMP.
- Makes registration for the PMP mandatory.
- Makes use of the PMP mandatory, pursuant to rules of the individual prescribing boards.
- Requires prescribing practitioners to report controlled substance dispensings to the PMP.
- Codifies Board rule requiring dispensings to be reported no later than "next business day".
- Grants the Board specific legislative authority to exercise a surcharge of no more than 25% of the controlled substance registration fee to fund ongoing efforts of the PMP.
- Mandates the electronic prescribing of all prescriptions (both controlled and non-controlled) beginning January 1, 2020.
- Grants the Board the authority to generate and send "proactive notifications."
- Requires the Board to provide prescribers with "activity reports" at least annually.

[29] HF2377 https://www.legis.iowa.gov/docs/publications/LGE/87/HF2377.pdf

- Requires the PMP to provide educational updates to prescribers regarding opioid prescribing and use.
- Permits the Board to change the renewal period for controlled substance act registrants.
- Aligns the Board's disciplinary process for CSARs with how the Board handles cases against all other licensees and registrants.
- Provides Good Samaritan immunity for naloxone administration.
- Includes the Board's recommendations for the rescheduling or scheduling of certain substances (mostly synthetic opioids and cannabinoids).

A bill, HF690[30], was passed in May 2019: an Act relating to mental health and disability services, including the establishment of a children's behavioral health system and a children's behavioral health system state board, and requiring certain children's behavioral health core services. The health IT impact within the bill updates the central data collection and management information system to a mental health and disability services system. An excerpt from HF690 is below:

> NEW PARAGRAPH. OOk. Establish and maintain a data collection and management information system oriented to the needs of children utilizing the children's behavioral health system, providers, the department, and other programs or facilities in accordance with section 225C.6A. The system shall be used to identify, collect, and analyze service outcome and performance measures data in order to assess the effects of the services on the children utilizing the services. The administrator shall annually submit to the state board information collected by the department indicating the changes and trends in the children's behavioral health system. The administrator shall make the outcome data available to the public.

OCIO Administrative Rules relating to IT procurements took effect on January 22, 2020. These rules apply to all participating agencies as defined under Iowa Code Chapter 8B.1(12), and can be found at Iowa Administrative Code 129—10 Procurement of Information Technology[31].

2.6 State Medicaid Agency MMIS and HIT/E Relationships

The Agency currently owns and maintains multiple systems and interfaces that facilitate the processing of Medicaid Member benefits and Medicaid administrative functions. The core MMIS legacy mainframe system continues to support the majority of Medicaid processing.

2.6.1 Current Medicaid Information Technology Architecture

Iowa Medicaid continues to move towards increased levels of MITA maturity with commitments to map operations to the business processes and improve technology. The most recent MITA Self-Assessment, 2015, informed the IME that Interoperability

[30] HF690 https://www.legis.iowa.gov/docs/publications/LGE/88/HF690.pdf
[31] Procurement of Information Technology https://www.legis.iowa.gov/docs/iac/chapter/01-15-2020.129.10.pdf

Condition was primarily at a Level 1 business capability; and the Technical Architecture Profile was at Level 1 as well. Steps towards improvement include the release of a Request for Information (RFI) to replace the existing MMIS with a modularized solution based on a common technical architecture in early 2019.[32] The As-Is MMIS System and Interface Layout can be found in Appendix F of the RFI.

The goal of the SMA's RFI is to gain innovative ideas and opinions about how Iowa can enhance its approach to deliver services in a manner that align with national best practices and evidence-based methods, which connect to payment and expected outcomes. The IME plans to deliver an updated MITA Self-Assessment as part of the Modernizing the Exchange of Information within the Medicaid Enterprise (MEME) Project planning effort in 2020. The RFI, Appendix D: Current Program and Technical Architecture Overview, contains detailed information about the current MMIS infrastructure; a legacy mainframe system.

2.6.1.1 Vision Statement

The Agency envisions implementing a flexible and modular MMIS that supports both Managed Care and Fee-for-Service (FFS) processes across the evolving health care landscape; serves as an enterprise payment, invoicing, and collection module; and provides the foundation for improved health outcomes and quality of care for Iowans.

2.6.1.2 Items Related to Promoting Interoperability Program

Iowa Medicaid providers and hospitals have adopted and implemented EHRs and have been incentivized to do so through the Iowa Medicaid Promoting Interoperability Program. The RFI section 2.3 Guiding Principles of implementing a new MMIS shows the future benefit to IME where provider and hospital adoption of EHR's have the potential to more efficiently electronically exchange health information as health information exchange purposes are discovered.

A new MMIS:

- Contributes to the state's overall goal of providing healthier outcomes for Iowans, improving efficiencies, and enhancing consumer experience while reducing cost of care
- Fits into a larger statewide IT ecosystem where appropriate and possible
- Allows for easier alignment of provider, MCOs and health initiatives in driving quality improvement and value based payment reforms, while improving accuracy and transparency
- Considers the "whole person" context as people change coverage frequently…especially "churn" in and out of Medicaid (and in & out of the different programs in Medicaid)
- Maximizes the use of cost-effective, industry-related, and application-ready Commercial Off-The-Shelf (COTS) technologies wherever feasible

[32] Request for Information Regarding MMIS Modernization MED 19-029 https://bidopportunities.iowa.gov/Home/BidInfo?bidId=bd232a61-9fcd-418e-a1fc-75dcd36220b1

- Integrates “best-of-breed” solutions
- Provides flexible rules-based technology to adapt to a dynamic health care industry and evolving state and federal standards, regulations, and processes
- Aligns with the business objectives of the IME and with current and any future federal and state regulations
- Supports the coordination of care and benefits among State Agencies and Public Health programs to support improved health outcomes of our members
- Provides capabilities to support provider and member centric business models
- Provides comprehensive and adaptable analytic reporting capabilities to support IME program needs

2.6.2 SMA HIT/E Relationships with Other Entities

The Medicaid Director participates in the Governor’s Healthcare Innovation and Visioning Roundtable, where there is participation from leaders around the state on how to transform how the healthcare system operates to best serve the need of all Iowans. As health information exchange adoption grows within the state of Iowa and across the country, IME will consider opportunities to connect and/or utilize services where applicable.

HIT initiatives are an important part in improving public health data quality and timeliness of provider reporting. The IME has ongoing HIT relationships with IDPH, who is helping to connect Medicaid providers to the public health registries. The registry connections assist Medicaid providers meet the requirements of the Promoting Interoperability Program. HITECH funding has been used to build and/or connect to the various public health registries. The IME and IDPH work closely together to meet contract and HITECH IAPD deliverables for the registry work.

Future opportunities for health information exchange exist between the two agencies as many times the Medicaid and Public Health programs are serving some of the same members of the population. Other health information exchange opportunity examples could include the recent SUPPORT Act where SMA’s have reporting requirements which could be a connection to the state PMP.

2.6.3 Patient Centered Medical Home

The IME’s State Plan Amendment requires that providers participating in the Health Home Program use an EHR.

2.7 SMA’s Relationship to the State HIT Coordinator

The IME has a State Health Information Technology Coordinator for the SMA which is through an IME contracted resource. The contractor oversees the Promoting Interoperability Program and coordinates with policy and other contractors involved in the Promoting Interoperability Program to achieve program and contract deliverables. The IME’s HIT Coordinator resource is accountable for tracking overall progress of and updating the IME’s SMHP and the HIT Implementation Advance Planning Document (IAPD). The HIT Coordinator oversees the Promoting Interoperability

Program. Activities included in PI Program oversight include pre-pay audit, post-pay audit, and state level repository PIPP system updates.

2.8 State Borders and Health Information Technology or Exchange

Iowa shares borders with Minnesota, Wisconsin, Illinois, Missouri, Nebraska, and South Dakota.

Iowa Medicaid has beneficiaries who could receive healthcare outside of the state. Such examples could include rural areas of the state lying along the border with beneficiaries seeking specialty care, such as in South Dakota. Other major cities which border the state such as Sioux City, Omaha, the Quad Cities, etc.; IME expects that there would be crossing of state lines for care. Minnesota borders Iowa to the north, and IME would expect that for some specialty care instances, members would seek care at Mayo Clinic.

The Iowa Prescription Monitoring Program is actively working on interstate connectivity and interoperability. Iowa's PMP is currently connected with IL, KS, ME, NY, OK, SD, WI, MN, MO, and ND. The PMP is actively working with NE, to achieve all contiguous interstate connectivity.

The Iowa Health Information Network, IHIN, has joined the Patient Centered Data Home initiative and is affiliated with the Western Region. IHIN has connected to the Sequoia Project and the eHealth Gateway.

The IME will continue to monitor HIE adoption within our borders and neighboring borders. IME expects that once the Trusted Exchange Framework and Common Agreement is finalized and rolled out, connectivity between providers, patients, payers, and others will be more prevalent for all who choose to participate. Connectivity and interoperability may also rapidly expand through the HL7 FHIR use cases and policies implemented which support the use cases.

2.9 State Immunization & Public Health Surveillance

The Iowa Department of Public Health has maintained a Promoting Interoperability Program, formerly Meaningful Use, website[33] where providers can find the status of Public Health registries and readiness for Meaningful Use reporting options. IDPH maintains the web page as the authoritative source of all public health reporting options supported by IDPH in Iowa. The page is updated as needed. IDPH provides links within the page with information on how to register and informative steps to connect to the registries.

IDPH registry readiness includes the following:

[33] For more information on Iowa Department of Public Health registries for the Promoting Interoperability Program https://idph.iowa.gov/InformationManagement/meaningful-use

- Immunization
- Electronic Lab Reporting
- Electronic Case Reporting
- Cancer
- Newborn Screening
- Prescription Drug Monitoring Program

2.9.1 Process for Public Health Data Registry Collection via HIE

- Immunization: Immunization exchange is a direct connection between the provider and the Iowa Immunization Registry Information System (IRIS). Bi-directional exchange and integration is available.
- Electronic Lab Reporting: Approximately half of ELR is a direct connection from the laboratory to the Department. The other half connect through the IHIN where the lab messages are sent and are translated through the Persivia SmartLab and then sent to the Department.
- Electronic Case Reporting: Capacity is being built for this. It does not flow through the IHIN but Direct Secure Messaging is utilized.
- Cancer: Cancer reporting is available for eligible clinics through the IHIN.
- Newborn Screening: Newborn screening can be sent with an ADT message through the IHIN, direct connection the the Department or data entry.
- Prescription Drug Monitoring Program: A VPN connection can be made to the PMP through the IHIN or directly from the provider to the PMP.

2.10 Grants

Iowa received grants pertaining to HIT developments between 2010 and 2015, such as:

- ONC HIE Cooperative Agreement Program
- Community College Consortium
- Regional Extension Center

2.10.1 State Innovation Model Grant[34]

Iowa was one of 11 State Innovation Model (SIM) Round Two Test States, awarded through the CMS Innovation Center. Iowa's model test began January 2016 and completed at the end of April 2019. Iowa was awarded $43.1 million over a four year period to support statewide health system transformation. The Iowa SIM Grant tested the sustainability of targeted care delivery improvement linked to value-based payment reform to improve population health. Goals included:

1. Healthcare costs are reduced while quality is improved with value based payment models
2. Patients are empowered and supported to be healthier

[34] More information on Iowa State Innovation Model https://dhs.iowa.gov/ime/about/initiatives/newSIMhome

3. Iowa increases the number of provider organizations financially successful in Alternative Payment contracts

The SIM incorporated HIT into the operational plan and established a Statewide Alert Notification (SWAN) system for providers participating in value-based care. The SWAN system was established under the IHIN. The SWAN aimed to connect a real-time flow of Admission Discharge Transfer (ADT) files from all 118 Iowa hospitals, MCOs and Medicaid ACOs to improve care coordination during critical transitions. The ADT infrastructure enabled real-time alerts to care teams when a patient had an emergency room discharge, an inpatient admission or an inpatient discharge.

The ADT capability established through the SIM grant assisted hospitals with realizing the benefit of this common communication mechanism to promote coordinated care and population health management. As Iowa neared the end of the SIM grant, the larger marketplace essentially determined that ADT notification functionality should sustain, but that additional capability surrounding the alerts would be preferred. As financing through SIM for the “simple” SWAN alerts ended, several health systems and IHIN transitioned to an improved solution through PatientPing. Iowa hospitals have been willing to pay for more robust notifications through their own contracts with vendors, such as PatientPing, or through PatientPing with the IHIN.

3 Section B: Iowa's "To-Be" HIT Landscape

3.1 Overview

Iowa's "To-Be" HIT landscape describes the health information technology and exchange vision and goals the IME expects to achieve over the next five years. This section also outlines how the IME will benefit from EHR and health information exchange adoption by Eligible Providers and Eligible Hospitals, and how the technical capabilities will impact the Medicaid Enterprise Systems for member health care improvement, value based initiatives, and care coordination. The IME's current HIT/E landscape is described in Section 2 of this document.

Iowa has experienced some transitions over the past few years including the transition to Managed Care Organizations, and the IHIN moving to a non-profit entity. The IME's focus remains on managed care implementation and onboarding, MMIS modernization with a modular approach, improved data analytics, improving member healthcare outcomes, and alternative payment models.

3.2 IME- Five Year Goals

The IME established four primary goals at the onset of the Promoting Interoperability Program which remain relevant for the next five years to maximize the quality and efficiency of the healthcare services our members receive. The IME is committed to supporting healthy outcomes for its members, and efficient and effective payments to providers.

- Increase provider adoption and meaningful use of electronic health records and health information exchange
- Improve administrative efficiencies and contain costs
- Improve quality outcomes for members
- Improve member wellness

3.2.1 Increase Provider adoption of Electronic Health Records (EHR) and Health Information Exchange

Central to the IME's HIT strategy is the need for information in electronic format. The IME supports EHR adoption and use through the administration of the EHR Incentive program, performing provider outreach, and encouraging the continued use of EHR enabled processes within the IME. Section 2 of this document provides details of EHR adoption, provider and hospital attestation numbers, and predictions of attestations IME believes to receive in the remaining incentive years.

The IME works closely with IDPH on health information exchange initiatives that impact Eligible Professionals and Hospitals ability to meet the public health Promoting Interoperability Program measures. IDPH has developed and/or is working

to develop and onboard participants to the public health registries[35]. IDPH's electronic lab reporting has been a valued and critical component for hospitals and labs, especially during the public health emergency in 2020.

As the DHS Enterprise Data Warehouse (EDW) is updated it will enable a storage architecture designed to hold and combine data extracted from disparate systems and external sources into a coherent, organized data model. As part of the DHS infrastructure, the EDW will be vital for managing disparate data sets across the DHS, and providing the architectural solution for decision-makers to access data for enterprise-wide data analysis and reporting.

Objectives:

- Providers will capture medical clinical information electronically and exchange the information with other providers.
- Administer Medicaid Promoting Interoperability Program.
- Providers utilize the state level repository, PIPP, to attest for EHR incentive payments. At this time there are no plans to use the PIPP system beyond the EHR incentive program. If additional EHR incentive programs for other Medicaid provider types (Behavioral Health, LTC, etc.36) become available in the future the SLR could potentially be reused for such a purpose.
- Support health information exchange; support the national health information exchange connectivity model (TEFCA) as it matures; investigate HL7 FHIR use cases.
- Assist providers who are not currently eligible for Medicaid incentive payments with connections for health information exchange purposes, so it benefits Medicaid Eligible Providers. Determine the appropriate technical assistance and support required to help those providers access appropriate electronic health information or adopt EHRs and exchange health information.

3.2.2 Improve Administrative Efficiencies and Contain Costs

As Iowa's providers continue to adopt EHRs, the IME will research and implement methods for transmitting clinical information between the IME and providers in the most efficient manner.

Objectives:

- Utilize health information exchange and EHRs where possible to provide information to providers.
- Utilize health information exchange where possible to eliminate the need for mailing or faxing of medical information between providers and the IME.

[35] IDPH Promoting Interoperability Program readiness information http://idph.iowa.gov/InformationManagement/meaningful-use

[36] HR 3331 115th Congress Promote Testing Of Incentive Payments For Behavioral Health Providers For Adoption And Use Of Certified Electronic Health Record Technology. https://www.congress.gov/bill/115th-congress/house-bill/3331/text

- Provide access to health information exchange for targeted providers where quality improvements yield cost reductions or containment for Medicaid.

3.2.3 Improve Quality Outcomes for Members

The IME believes that the continued use of EHR/HIE technology will improve the care members receive. More complete information at the time of care will decrease errors in care delivery and improve the overall care members receive.

Objectives:

- Improve care transitions between provider settings.
- Decrease hospital readmissions from Long Term Care Facilities. Provide Discharge Instructions and Continuity of Care information real-time from Hospitals to LTC via EHR & HIE adoption.
- Decrease LTC readmissions from Home Health Services. Provide Discharge Instructions and Continuity of Care information real-time from LTC to Home Health Services via EHR & HIE adoption.
- Support patient/home health collection of relevant vitals via HIE patient/home health portals.
- Utilize Health Information Technology to expand the application of evidence based treatment.
- Capture Quality Measures for monitoring provider performance.
- Determine if correlations between quality measures and underserved populations exist.

3.2.4 Improve Member Wellness

Providing members with access to their clinical information and information on wellness/self-care practices will improve member's wellness and decrease the need for treatment.

Objectives:

- Provide members with information regarding their personal health.
- Provide Medicaid member's care teams with clinical information.
- Provide members with wellness education.
- Maintain a Medical Home model that promotes healthy outcomes and manages the member's chronic health conditions.

3.3 Medicaid Information Technology Architecture To-Be Within Next 5 Years

Through the release of an RFI[37] in early 2019 to update the MMIS architecture, the Agency envisions implementing a flexible and modular MMIS that supports both Managed Care and Fee-for-Service (FFS) processes across the evolving health care landscape; serves as an enterprise payment, invoicing, and collection module; and

[37] MED 19-029 RFI Regarding MMIS Modernization
https://bidopportunities.iowa.gov/Home/BidInfo?bidId=bd232a61-9fcd-418e-a1fc-75dcd36220b1

provides the foundation for improved health outcomes and quality of care for Iowans. The Agency's interoperability goal is for the MMIS solution to seamlessly integrate with other enterprise systems to drive proper utilization of benefits, healthier outcomes and future population health initiatives.

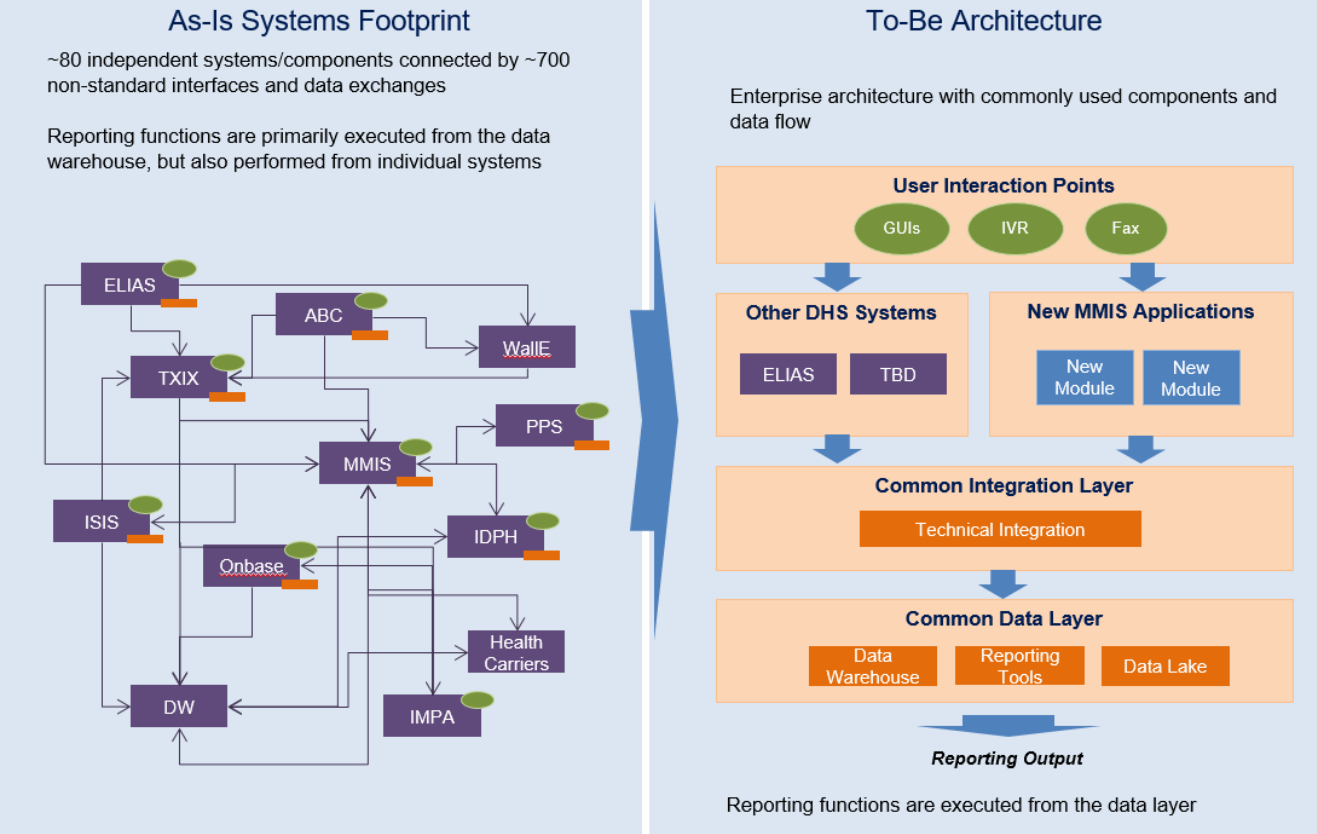
The MMIS solution will provide a framework to support the broader Agency Enterprise and will serve as an information gateway for all Agency stakeholders. The solution must support effective automation and paperless transactions across traditional program lines, facilitate data access and exchange in real-time while ensuring compliance with privacy and security and enable effective and timely transfer of information to program users. In addition, the solution is envisioned to include a consolidated, easy-to-use and appealing user interface (e.g., portal, social media, call center) to provide an enhanced customer service experience for providers and clients.
The future state of the MMIS solution will be:

- Modular
- Tools Driven
- Adaptable
- Sustainable
- Service Focused

The Current State to Future State is pictured below, as presented in the RFI[38].

[38] MED 19-029 RFI https://bidopportunities.iowa.gov/Home/BidInfo?bidId=bd232a61-9fcd-418e-a1fc-75dcd36220b1

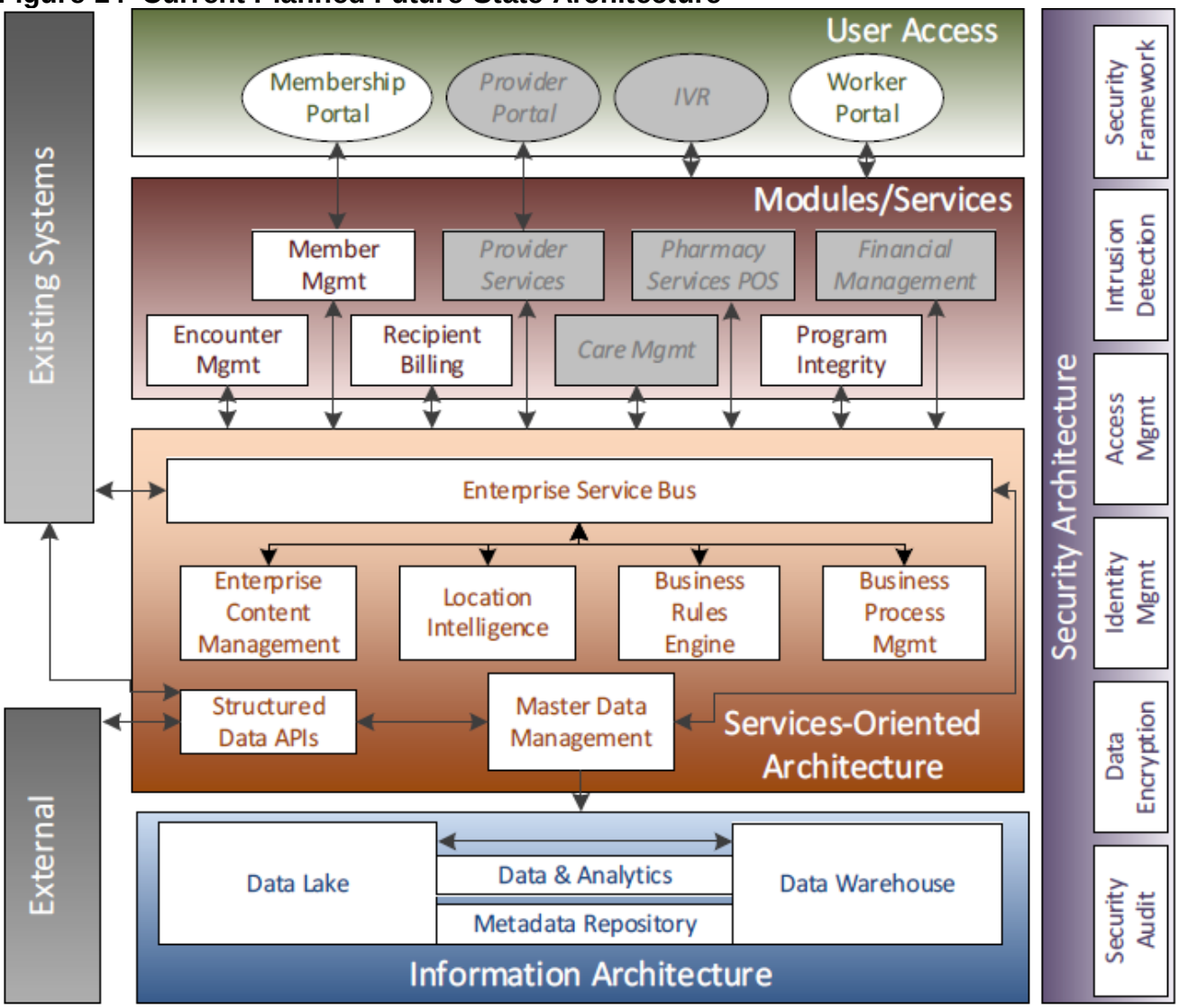
Figure 13 Conceptual MEME Implementation Approach – Current State to Future State



The rollout will occur in phases. The first phase focuses on the MAGI eligible members covered by managed care providers. The diagram below reflects the currently planned future-state architecture from the RFI[39]. (Post phase 1 user and module components are shown in gray.)

[39] MED 19-029 RFI https://bidopportunities.iowa.gov/Home/BidInfo?bidId=bd232a61-9fcd-418e-a1fc-75dcd36220b1

Figure 14 Current Planned Future-State Architecture



Future phases focus on non-MAGI eligible members and fee for service members. Additional modules and other technical integrations will be developed to support unique requirements of each phase. Changes will be made to existing modules and components as part of each phase delivery.

The MMIS Module Procurement Strategy includes plans for a member portal and an Enterprise Data Warehouse (EDW). The member portal will provide a 'one stop' destination for accessing benefits, charges, educational information, and other Agency communication. The EDW solution will provide data warehousing and data integration capabilities for data to be shared across system boundaries, and will include historical data, data required for real-time operational data stores, and the analytical tools needed for accessing the data using advanced and predictive data analytics. The Agency is planning to advance its Data and Analytics Maturity Model,

specifically in the areas of predictive modeling, risk analysis and mitigation, and data for strategic planning.

3.4 Issues to be addressed within the Next Five Years to Achieve Goals

Within the next five years the IME anticipates significant progress will be made towards the development of seamless and integrated systems that communicate effectively to achieve common Medicaid goals through interoperability and common standards with the MEME project described in the RFI. The challenges the Agency will have to overcome are included in the RFI 2.4.3, and are summarized as follows:

- Lack of standards of MMIS modules and data models making it difficult to integrate and exchange data between modules.
- The Medicaid Program is changing and continues to become increasingly complex. Many changes are being discussed in Congress related to funding for the Medicaid Program. In addition, the Agency recently transitioned to a managed care model.
- Data integrity through the transition to modern technology.
- System integration is iterative and ongoing. Enterprise solutions require monitoring, maintenance, and support. Changing business needs and technology require ongoing changes.

3.4.1 Other Issues which would need to be addressed to Achieve Broad Health Information Exchange and Interoperability

The following could assist the IME for broader health information exchange to occur and be more viable

- Build Additional Infrastructure – broadband initiatives impact rural Iowa for improved capabilities for health information technology and exchange
- Develop and mature specific use cases which encourage and benefit provider and payer participation in exchanging health information
- Standardized Data Governance and Legal Governance to establish trust
- Continued standards development and implementation across health information technology
- Continued development and implementation of standardized quality measures and electronic reporting practices

3.5 Health Information Exchange to Achieve IME's HIT/E Goals and Objectives

Future capabilities to connect with Iowa's strategy for an evolving health information exchange to communicate with other stakeholders (e.g. clinics, lab) to drive a 'whole person' approach to population health and care gap initiative is carried out by the Governor's Healthcare Innovation and Visioning Roundtable[40]. The Governor's Healthcare Innovation and Visioning Roundtable continues to meet and brings stakeholders together to discuss and mature strategies and use cases for the following topics:

[40]Governor's Healthcare Innovation and Visioning Roundtable
https://dhs.iowa.gov/ime/about/initiatives/newSIMhome/roundtable

- Data Sharing and Use
- Healthy Communities

3.6 Promoting Interoperability Program Interface with MMIS

The RFI shows the current MMIS system and Interface Layout in Appendix F. The PIPP system interfaces with Onbase and Core MMIS. The systems communicate to ensure eligibility and process the incentive payments. The PIPP system uses the National Level Repository-State Level Repository electronic interfaces to communicate registration, payment, and audit data information between the two systems for the Promoting Interoperability Program.

3.7 Promoting Interoperability Program – Encourage Provider Adoption/Use of CEHRT

See Section 2.1.3 and Section 4 for information regarding EHR adoption, meaningful use returning providers, and outreach efforts.

3.8 Promoting Interoperability Program – Addressing Populations with Unique Needs, such as Children

See Section 2.1.3 for information regarding EHR adoption, meaningful use returning providers, and outreach efforts, and section 2.5.5 pertaining to HF690.

Iowa Medicaid collects patient volume as part of the Promoting Interoperability Program. The patient volume shows how many Medicaid encounters and how many total encounters occurred, or how many patients benefitted from the use of EHRs. IME collects patient volume for providers attesting to the program which includes numerators (Medicaid patients) and denominators (total patients) during the reported period. The data reported here shows the pediatric providers who attested to the program since inception; how many encounters some of Iowa's most vulnerable patient population has been served by pediatric providers who use certified EHRs and participate in the Promoting Interoperability Program.

297 unique pediatricians have attested with the Iowa Medicaid Promoting Interoperability Program. Since the inception of the program the pediatricians have submitted 982 total attestations. The number of pediatricians' Medicaid encounters reported from program inception totals approximately 2.3 million (numerator of patient volume) Medicaid children member encounters out of a total number of encounters reported by the pediatricians of approximately 4.9 million (denominator of patient volume). The Promoting Interoperability Program has impacted at least 4.9 million children encounters reported by pediatricians participating in the Iowa Medicaid Promoting Interoperability Program.

3.9 Legislation Changes to Existing State Laws to Implement EHR Incentive Program or Health Information Exchange

The SUPPORT Act reporting requirements for State Medicaid Agencies to access prescription monitoring program data would require a change to Iowa legislation. The current PMP rules, Iowa Code Chapter 124 Controlled Substances, restricts information access[41].

3.10 HIT-related Grant Awards Impact on Promoting Interoperability Program

The State Innovation Model grant[42] impacted the Promoting Interoperability Program by engaging multiple stakeholders in activities which involved the use and development of HIT/E solutions. Specifically, the SIM grant tested sharing of alert notifications to coordinate care, called the State-wide Alert Notification, or SWAN, system.

Providers and MCOs submitted a monthly list of Medicaid members they managed. Then the SWAN system produced a daily digest of members that had an emergency room discharge, admission, or inpatient discharge from participating hospitals. The SWAN digest allowed health systems to connect with members they may have not otherwise known needed assistance and to provide follow up after the emergency room or hospital stay.

The SWAN system connected 52 of 118 hospitals in Iowa for ADT alert notifications. The SWAN system tested and demonstrated the need and desire of hospitals to exchange health information to coordinate care by way of alert notifications. At the end of the grant period, hospitals had recognized the value of these alerts, and advanced from the free but basic SWAN alerts offered through SIM to direct financing of more robust alert notification systems, primarily PatientPing.

[41] Iowa Code Chapter 124 https://www.legis.iowa.gov/docs/code/124.pdf
[42] State Innovation Model grant https://dhs.iowa.gov/ime/about/initiatives/newSIMhome

4 Section C: Iowa's EHR Incentive Payment Program

4.1 Overview

This section describes the process(es) required for the administration of the incentive payment program, including capturing attestation for eligibility, meaningful use and clinical quality measures.

4.1.1 IME Implementation of Promoting Interoperability Program & Contractors

Iowa Medicaid Enterprise (IME) is responsible for administering the Iowa Medicaid Program, and implemented a model where professional services vendors work cooperatively with the Department staff to perform the Medicaid functions. Each vendor brings its specific expertise and knowledge to the IME. The Department maintains ultimate authority and responsibility for the Medicaid program and hires those with expertise in specific domains.

Therefore, the IME chose to implement the Promoting Interoperability Program using the same model. The contracted resources in the relevant units within IME perform the work, administer the Promoting Interoperability Program, and work with and report to Department staff. The contracted staff coordinate activities as needed with other business units within IME such as Medical Services, Core Services, Provider Services, Provider Audit, and Program Integrity to accomplish requirements of the program.

4.2 Outreach and Provider Support

The IME has implemented several communication mechanisms to educate providers on the incentive program. The primary methods of outreach include phone calls and emails. The IME established a dedicated email account (imeincentives@dhs.state.ia.us) as the primary contact method for communication. E-mail correspondence is sent to providers and hospitals advising of attestation deadlines, updates and tools available on the program webpage, and information regarding application submissions and corrections. The email correspondence utilizes the email address the provider entered on the CMS registration and attestation site.

4.2.1 Support through Prepayment Process

Upon review of the attestation by the prepayment auditor, if the attestation is missing information or the prepayment auditor finds a requirement is not met, the attestation is returned to the provider through the PIPP system, and an email explaining the issues found is sent to the provider. Follow up emails and phone calls to the provider are made to ensure they understand what attestation updates need to be made prior to resubmitting the attestation to the IME. If the provider does not return the attestation or respond to the prepayment auditor, follow up is performed using a PIPP system 'Application Returned Report'. The HIT Advisor continues outreach until options are exhausted to meet the program requirements or the provider stops responding.

The HIT Advisor is the main point of contact and performs continuous outreach to assist providers to attest to the current and upcoming program years. The HIT Advisor maintains a tracking tool that includes the primary point of contact for the organization attesting for the providers and hospitals, tracks any barriers to attesting for the current program year, and program participation plans for future program years. Discussion between the HIT Advisor and HIT Coordinator occurs and any clarification from or questions to CMS are communicated appropriately. The IME has continued exceptional ongoing provider support for the program to handle the following:

- Continued provider outreach
- Provider help line for answering basic provider questions, including technical assistance for the online tool
- Responding to provider e-mails through a dedicated incentive program e-mail box
- Verification of provider eligibility and attestation review
- Approval of payments
- Assistance during appeals

The incentive payment program HIT Coordinator role offers additional guidance to the Promoting Interoperability Program staff and addresses unique provider questions or escalated issues. The HIT Coordinator is the primary contact for the Promoting Interoperability Program interactions with CMS.

Audit functions are described in further detail in section D of this document.

4.2.2 Outreach Activities

Figure 15 Outreach Activities

Outreach Activities						
Activity	Description	Counts				
		2016	2017	2018	2019	2020 *as of October 31, 2020
Phone Calls	Direct phone calls to provider organization contact	1434	1513	1008	749	221
Emails	Direct email to provider organization contact	684	3145	2272	2346	1419
Email through PIPP System	Email to contacts within the PIPP system Advertising IME HIT/PI Program Website updates, tools, and information and PIPP system attestation open/close dates (over 650 unique email addresses)	5	2	1	1	3
Informational Letters sent through IMPA	Informational Letters are sent out to the relevant providers signed up in the Iowa Medicaid Portal Access (IMPA), provider portal, system by the Iowa Medicaid Enterprise and posted to the IME website.	4	1	2	0	0
IDPH IHIN Health IT Wins Emails	Collaborated with IDPH for Health IT Wins communications which were distributed by email to over 400 contacts	11	3			
Webinar	A pre-recorded webinar was posted to the website and a requested webinar was presented to FQHC/RHCs. The outreach was performed to engage EPs and EHs to attest for the 2016 incentive year, provide program and SLR updates, and show and explain attestation tools available.	0	2			

Figure 16 Dentist Targeted Outreach Activities

Dentist Targeted Outreach Activities			
Activity	Description	Counts	
		2016	2017
Dentist TA Conferences/Exhibitis	Technical Assistance personnel presented at the Iowa Dental Association annual meeting in May 2016 to inform an educate dentists abou the Iowa Medicaid Promoting Interoperability Program, encourage dentists to participate and return for MU.	1	0
Phone Calls	TA resource performed phone calls to assist dentists in moving from AIU to MU or to assist dentists to begin participation in the Iowa Medicaid MU program.	729	400
Emails	TA resource performed email communications to assist dentists in moving from AIU to MU or to assist dentists to begin participation in the Iowa Medicaid MU program.	84	122
Webinar	The TA resource presented a summer series of webinars in June, July, and August 2016 and the recorded webinar sessions and slides were posted to the IME website.	3	0

Figure 17 Implemented Tools and Direct Outreach

Outreach Activities		
Activity	**Implementation Date**	**Resource**
Patient Volume Guidebook for Providers	April 2016	https://dhs.iowa.gov/ime/providers/tools-trainings-and-services/medicaid-initiatives/EHRincentives
Hospital Patient Volume Calculation Template	April 2016	
Dentist Technical Assistance and Webinars	2016	Webinar presentations and informational materials posted to website. Informational Letter sent through IME distribution and posted to IME website.
Provider Outreach Tracker and Contact Plan	September 2017	Internal Document
Perform Website Updates	Ongoing thru 2022	https://dhs.iowa.gov/ime/providers/tools-trainings-and-services/medicaid-initiatives/EHRincentives
Direct Outreach by phone and email to Providers	Ongoing thru 2021	Outreach Tracker and PIPP system

4.2.3 Provider Resources

4.2.3.1 PIPP Attestation Website and User Manual

The PIPP system can be found at www.imeincentives.com. Links to resources are listed on the left side of the screen, and contact information and the user manual are located on the right side of the screen for easy access to assistance and information.

4.2.3.2 IME HIT & PI Program Website

Since 2010, the IME has updated and maintained the DHS Health Information Technology and Promoting Interoperability website[43]. The IME provides contact information for the HIT Advisor and HIT Coordinator on the program webpage. The website is kept up to date with guidance, information, and links to assist providers and hospitals to attest to the current and upcoming Promoting Interoperability Program years. Some of the most used resources the IME has developed for providers and hospitals to guide them on eligibility are the Patient Volume Guidebook for eligible professionals and three tools for hospitals including an EH tip sheet, patient volume calculation tip sheet, and hospital calculator.

4.2.4 Hospital Outreach

Some hospitals had not yet attested with the Iowa Medicaid Promoting Interoperability Program in 2016, and others had not yet received all three incentive payments. Targeted outreach was performed to hospitals to relay the program specific and consecutive attestation requirements. Informational materials were posted to the IME website to assist hospital attesters with patient volume and payment calculations as well as a tip sheet. Direct outreach by phone and email continued with the hospitals for Program Year 2016 until either the hospital responded that they did not plan to attest or the attestation was submitted to the IME for review.

The IME HIT Advisor continued direct outreach for the 11 hospitals eligible to attest for Program Years 2017 and 2018. The outreach continued until the attestation was

[43] Iowa Medicaid Health Information Technology and Promoting Interoperability Program https://dhs.iowa.gov/ime/providers/tools-trainings-and-services/medicaid-initiatives/EHRincentives

received in the PIPP system for review. IME completed the hospital incentive payments per the consecutive attestation rule in Program Year 2018.

4.2.5 Dentist Outreach

During 2016 and early 2017 targeted outreach to dentists was performed. The IME recognized that dentists had not returned to attest to Meaningfully Use of their EHR system. As such, meetings were held with the Iowa Dental Association (IDA) to assist in outreach opportunities to dentists, and in turn IDA posted communications to their blog regarding the Promoting Interoperability Program last chance to enter the program in 2016 and the opportunity to return for meaningful use. IDA also invited the IME to present at their annual conference. The IME's dental MCOs communicated with providers regarding the program. IME contracted with Telligen, the former HIT Regional Extension Center for Iowa. Telligen provided direct phone calls, emails, resource information, webinars, and presented at the IDA conference. The IME processed incentive payments for 70 new AIU attestations, and five meaningful use attestations for Program Year 2016.

4.2.6 Lessons Learned

As an early launcher, the IME has many lessons learned over the program. The IME has performed process improvements over time and mitigated attestation issues by providing resources such as the Patient Volume Guidebook, Hospital and Dentist resources, updated guidance posted to the IME's HIT and PI Program website, and ongoing direct outreach to the primary attestation contacts. As the PIPP system has been updated with more reporting functionalities, and as post-payment audits have been performed, IME has taken the available information and lessons learned and implemented a more robust outreach and pre-payment audit process, and PIPP system updates to resolve the issues.

Issues which have been resolved over the years include:

- The IME does not require certain providers to be enrolled to bill even though they are treating Medicaid patients. If a provider is not currently enrolled to bill as an Iowa Medicaid provider an additional electronic agreement signature page is displayed requiring the provider to either agree or disagree with the statements listed as part of the attestation process.
- An assumption in the planning phase was that the IME would be able to validate the numerator in the patient volume calculation. It quickly became apparent that we would need to rely on provider records, even for the numerator. Providers needed additional patient volume guidance so the IME is able to validate the numerator for various claims scenarios. A patient volume guidebook was created with scenarios, definitions, and information the IME needs to validate the patient volume.
- Hospitals needed additional guidance on the aggregate payment calculation and patient volume, so the IME posted tools on the IME HIT and PI Program website.

4.3 State Medicaid Agency Options

The IME identified all of the state options and these options are included in the State administrative rule[44]. The list of state options includes:

- Pediatrician definition
- Clinic definition
- Which fiscal year to use for hospital patient volume
- Timeframe for average length of patient stay
- Payment methodology for hospitals
- Zero Paid Encounters Method for calculating patient volume

4.4 Promoting Interoperability Program Attestation and Pre-Payment Audit Process

In designing the incentive payment process, the IME developed a high-level process flow to serve as a visual point of reference. Process descriptions provide additional details on some of the specific steps involved. The processes discussed in this section include:

- Registration and Attestation
- Pre-Payment Audit

The PIPP system (State Level Repository or 'SLR') automatically communicates with CMS' National Level Repository (NLR) system throughout processes described below using the NLR-SLR Electronic Interfaces. Section 4.7 contains a system workflow between PIPP, MMIS, and CMS.

4.4.1 Provider Registration and Attestation

This section describes the application steps to submit an attestation to IME for review. Detailed information regarding the attestation process for providers and hospitals is contained in the PIPP User Manual.[45] Provider attestation is completed online in the PIPP system[46].

Table 4 Registration and Attestation Process

Step	Action
1	Provider (EP or Hospital) registers with the CMS Registration and Attestation site. This is a site maintained by CMS where providers declare the state from which they are applying to receive Medicaid incentive payments. This registry is also used to prevent duplicative payments with Medicare for EPs. Providers are

[44] IAC Ch 79, 441-79.16(249A) Electronic health record incentive program. https://www.legis.iowa.gov/docs/iac/chapter/441.79.pdf
[45] PIPP System User Manual https://www.imeincentives.com/PublicDoc/UserManualProviderIA.pdf
[46] PIPP System https://www.imeincentives.com/Default.aspx

Step	Action
	required to provide basic data, such as their NPI, SSN, payee TIN (if assigning their payment) and hospitals provide their CCN.
2	The IME is notified of a provider's application via daily batch file from CMS. The daily batch is fed into the Provider Incentive Payment Program (PIPP) system, an online attestation system (www.imeincentives.com).
3.	When PIPP receives the registration file from CMS, it sends a response file to CMS reflecting that the providers may register in PIPP. In addition, an email notification is sent to the provider telling them to register in the PIPP system and proceed with attestation.
4.	The provider accesses the Iowa PIPP system at www.imeincentives.com and establishes a user name and password by entering the NPI, tax id and CMS registration number. This triggers an activation email to the email address received from the CMS R&A site. The provider clicks on a link within the email to activate the account.
5.	The provider logs into the PIPP system and proceeds through the attestation process, uploading required supporting documentation as part of the process.

4.4.1.1 Electronic Signature and Proof of Assertions

The provider must electronically sign. The electronic signature contains a statement that the "signing" provider is authorized to receive payment, that all information provided is accurate, the provider is subject to legal penalty for providing false information, and that any funds expended under false pretenses will be recouped. When attesting, providers affirmatively acknowledge that proof of all assertions should be maintained for six years in the event of an audit. In the event of an audit, providers may be required to provide additional documentation.

4.4.1.2 Patient Volume

Iowa modified its approach to patient volume as "trust but verify" per the Stage 2 final rule. Per the Stage 2 final rule, IME re-defined allowable encounters to any Medicaid-eligible encounter including claims which Medicaid did not pay expecting more providers will be able to meet the patient volume threshold. IME asks providers to supply documentation as part of their patient volume attestation per the Patient Volume Guidebook[47] to avoid re-work on both sides. Providers should be prepared to breakout their patient volume into the following categories:

- Paid Claims
- Zero-Paid Claims
- Unbilled encounters
- Denied Claims

[47] Patient Volume Guidebook https://dhs.iowa.gov/ime/providers/tools-trainings-and-services/medicaid-initiatives/EHRincentives

- Medicare crossover encounters

Providers need to prepare documentation to support unbilled, denied, zero-paid, and Medicare crossover encounters by providing a list of state Medicaid ID numbers and dates of services. The Patient Volume Guidebook is posted on the webpage to assist providers with definitions and expectations of documentation needed in various scenarios.

Provider attestation is completed online in the PIPP system, with the use of an electronic signature. The electronic signature contains a statement that the "signing" provider is authorized to receive payment, that all information provided is accurate, the provider is subject to legal penalty for providing false information, and that any funds expended under false pretenses will be recouped. An additional agreement is required for those providers who are not enrolled to bill in Iowa Medicaid, such as Physician's Assistants or providers employed by a rural health clinic who bill under the RHC. The system documents that these requirements have been sworn to and provides an audit trail to track the secure login ID of the person attesting. The attestation questions and both EHR provider agreements are within the PIPP User Manual.

4.4.1.3 CEHRT Requirements

All providers are required to provide a certification number that can be verified with the Certified HIT Product List (CHPL). For each program year and attestation submitted PIPP automatically verifies that the EHR that was adopted, implemented or upgraded is certified. To qualify for the EHR incentive program, the provider must show that they have the current, required version of certified electronic health record technology (CEHRT).

4.4.1.3.1 CEHRT thru 2017

The following is acceptable documentation for such proof through program year 2017:

- A page of the contract or lease showing the provider, vendor, and name of the certified EHR technology and the dated signature page.
- If the current contract/lease agreement requires the vendor to provide you with appropriate updates/upgrades including certified EHR technology, a signed and dated copy of amendment/attachment showing the installation of certified EHR technology.
- A copy of your invoice or purchase order identifying the vendor and certified EHR technology being acquired and proof of payment.
- A dated and signed letter from the EHR vendor on the vendor's letterhead to the facility for which you are attesting, the facility name and address location stating that the facility has adopted/implemented/upgraded, the deployment date, the CEHRT version number as well as the facility signature.

4.4.1.3.2 CEHRT 2018

To qualify for the 2018 EHR incentive program the provider must have Electronic Health Record Technology certified to either the 2014 Edition or 2015 Edition (or a combination of the two).

The following is acceptable documentation for such proof:

- Vendor letter
- Receipt (Proof of purchase)
- Contract

All information listed below must be included in the documentation:

- Vendor name
- Product Version (2014, 2015 or combination which meets all Meaningful Use requirements)
- Facility name and address
- Signature(s)
- Date showing either the 2014 or 2015 Edition (or a combination) was used during the 2018 EHR reporting period

4.4.1.3.3 CEHRT 2019

Beginning in 2019, all eligible professionals (EPs) are required to use 2015 edition certified electronic health record technology (CEHRT) to meet the requirements of the Promoting Interoperability (PI) Programs.

The following is acceptable documentation for such proof:

- Vendor letter
- Receipt (Proof of purchase)
- Contract

All information listed below must be included in the documentation:

- Vendor name
- Product Version (2015 which meets all Stage 3 Meaningful Use requirements)
- Facility name and address
- Signature(s)
- Date showing 2015 Edition was used during the EHR reporting period.

4.4.1.4 Meaningful Use

Providers may choose to demonstrate meaningful use in their first year. All participating providers must demonstrate meaningful use for the second and subsequent participation year(s). IME directs providers to CMS' Promoting Interoperability website[48] for program information for the corresponding program year.

[48] CMS Promoting Interoperability Programs https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/index.html

4.5 Attestation Tail Period

The IME has typically set the tail period within the first 90 days of the following calendar year. As the program sunsets, per the rule payments must be made by 12/31/2021, the IME plans to allow a shorter attestation timeframe for the last three program years. This plan is pending CMS' final rule for the eCQM reporting period in 2020 and direction on Security Risk Assessments. The plan is also reliant on eCQM or other program updates or changes needed and the programming time into the PIPP system.

Figure 18 Attestation Tail Period

Program Year	Payments Occur in FFY	Planned Attestation Open Date	Planned Attestation Close Date	PrePayment Process and Payment Complete Target	Predicted # EP Attestations	Total Predicted Program Year Payment Amount
2020	2020/2021	7/1/2020	2/28/2021	6/30/2021	150	$1,275,000
2021	2021/2022	7/1/2021	8/31/2021	12/21/2021	100	$850,000

4.6 Prepayment Audit Process

The IME instituted a prepayment audit process where prior to paying the incentive, the attestation is reviewed by two separate prepayment auditors working independently. This approach serves as a quality control function. In the event of a disagreement on whether or not to issue the payment, the application goes to a supervisor review queue in PIPP for the HIT Coordinator to review. Applications are reviewed on a first-in, first-out basis process in the review queue in a timely manner.

In this section, the IME describes processes for reviewing attestations. At any point in the process, the Prepayment Auditor may return the attestation to the provider because the attestation is missing supporting documentation or an internal validation results in the need for more information or attestation corrections. The Prepayment Auditor may coordinate with other states if the provider sees patients across state lines.

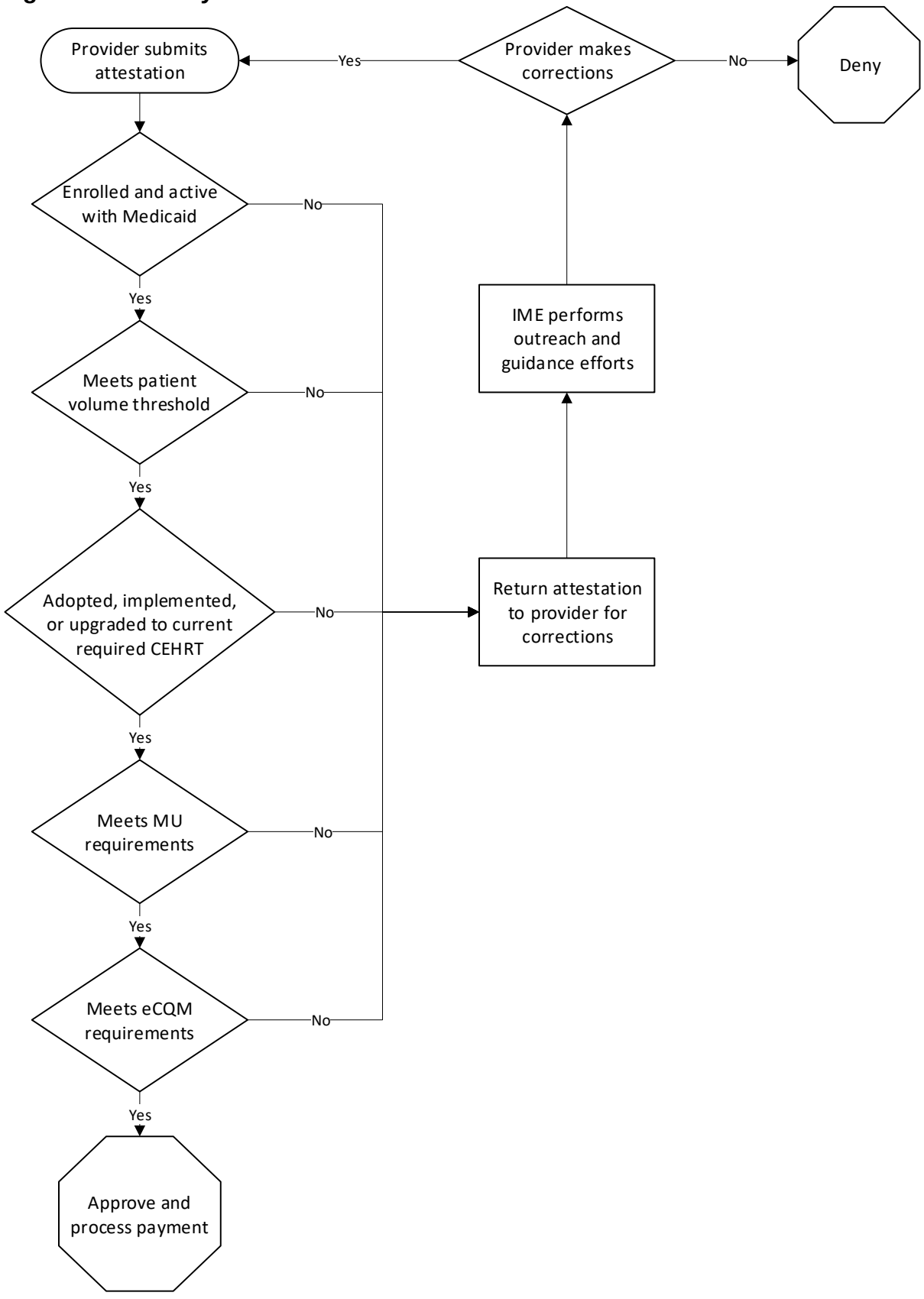
The attestation system, PIPP, contains a number of data elements, many of which the IME verifies by reviewing the provider's supporting documentation they attached to the attestation in PIPP. The IME verifies the TIN and NPI combination received from the CMS Registration and Attestation site in the MMIS in compliance with 42 CFR 495.10(f). This check ensures that the individual NPI has a relationship with the TIN provided. If necessary, the IME will request proof from the provider of the relationship with the payee TIN indicated on the application.

Table 5 Pre-Payment Audit Actions Performed

The provider completes and submits online attestation in PIPP following CMS' program requirements for the applicable program year. The provider can refer to the PIPP User Manual for guidance.
Provider enrolled and active with Medicaid? Prepay auditors perform a check in the MMIS system to ensure the provider is enrolled and active in MMIS. If the provider is enrolled and active with Medicaid according to the MMIS, the provider has passed the OIG sanctions and licensing checks as part of the enrollment process. The CMS system will also have checked for OIG sanctions.
Is the EP assigning their payment to a Managed Care Organization (MCO)? (Iowa has not had any providers assign their payments to an MCO) The Pre-Payment Auditor verifies TIN and NPI matches the MMIS system, if there is a discrepancy, outreach is performed. In the case that a payment was assigned, the Pre-Payment Auditor ensures payment does not exceed 105% of the capitation rate. Payments made through managed care plans cannot exceed 105% of the capitation rate, in compliance with Medicaid managed care incentive payment rules. If the payment is found to exceed 105% of the capitation rate, the payment cannot be made.
Providers are permitted to assign their incentive payments to state-designated entities promoting the use of EHR and HIT. There is no such state-designated entity in Iowa. The verification of voluntary assignment and 5% spending applies only to EHR-promoting entities, not to payments assigned to employers. Verify assignment is voluntary. The provider must assert the assignment to the entity is voluntary. The rule requires all assignments to an entity promoting the adoption of certified EHR technology are voluntary to the EP involved.
Is the provider hospital based? Pre-Payment auditor checks reports to verify. Individual providers who are deemed to be "hospital-based" are not eligible to receive the incentive payment.

Patient Volume Verification. The IME accesses claims data to determine the number of Medicaid encounters for the provider in the designated reporting period from the previous calendar year. The provider is required to indicate both the numerator and the denominator, along with the beginning and end dates of the reporting period. Proof of patient volume is required and can be EHR reports or other documentation with de-identified patient data for the designated reporting period. In the event more patient information is required for validation, IME requests the member ID and date of service. Providers must attest whether their numbers include inpatient encounters. Providers who want to use 'group' or 'clinic-level' proof of patient volume may do so by counting all of the clinic encounters and excluding encounters an EP has outside the clinic. Iowa defines "clinic" as being a separate billing NPI, tax ID, or physical location. Providers attesting that they are using group patient volume must indicate how they are defining the group and all other providers matching that criteria are required to use the same group approach for reporting patient volume. The IME runs reports to validate the encounters for which the provider has attested. Providers that do not meet the required patient volume threshold are not eligible to receive an incentive payment.
Patient Volume Verification - Has the EP practiced predominately in the FQHC/RHC? Providers attesting that they practice in an FQHC/RHC and who are using needy individuals to reach the 30% patient volume threshold are required to show they practice predominately in an FQHC/RHC. This means showing that the clinical location for over 50 percent of his or her total patient encounters over a period of 6 months in the most recent calendar year occurs at a federally qualified health center or rural health clinic.
Verify provider adopted, implemented or upgraded to the current required version of CEHRT.
Verify provider meets MU requirements.
Verify provider meets eCQM requirements.
Pre-Payment Auditor Decisions: Approve for payment. Return attestation to provider for corrections. Deny the attestation.

Figure 19 Pre-Payment Audit Process



4.6.1 Meaningful Use Pre-payment Verification

The IME's PIPP system is updated as needed to comply with the rule changes and measure changes for the Promoting Interoperability Program. The User Manual contains the questions included in the attestation system for both eligible hospital and provider attestations. The User Manual contains detailed information regarding the attestation process for the user, and was most recently updated in August 2019. The various attestation screens require supporting documentation be uploaded to support the attestation. The PIPP system performs some checks automatically such as the CEHRT number verification.

IME's PIPP system includes questions for meaningful use and electronic clinical quality measures (eCQMs). The provider manually enters the attestation information for meaningful use and eCQMs into the system. For meaningful use and eCQM requirements, the IME relies on the provider to upload supporting documentation generated from their CEHRT system to the attestation. The questions for meaningful use can be found in the PIPP User Manual. The pre-payment auditor verifies the meaningful use measures attested to with the supporting documentation provided.

4.6.1.1 State Required Additional Meaningful Use Criteria

The IME has no plans to mandate additional meaningful use criteria to the minimum measures required under the rules.

4.6.2 Incentive Payment Assignment

Eligible professionals are permitted to assign their incentive payments to state-designated entities promoting the use of EHR and HIT. At this time, Iowa has not designated such an entity. If, however, this changes and the state does designate an entity, the IME has built verification steps into the flows to ensure that the assignment is voluntary and that the entity does not retain more than 5% for costs unrelated to EHR promotion.

To date no payments have been assigned to managed care organizations. If this happens, the process to assure payments through Medicaid managed care plans do not exceed 105 percent of the capitation rate is included in the review process.

4.6.3 Incentive Payment Amounts for EPs

For the first payment year, payment will not $21,250. Subsequent incentive year payments will be $8,500. Pediatricians with a Medicaid patient volume between 20% and 29% receive 2/3 of that amount, $14,167 for the first payment year and $5,667 for subsequent years, not to exceed $42,500. Maximum Medicaid incentive payment amount for EP across the six payment years is $63,750.

For purposes of the Iowa Medicaid Promoting Interoperability Program the definition of pediatrician is: a physician who is board-certified in pediatrics by the American Board of Pediatrics or the American Osteopathic Board of Pediatrics. When a

pediatrician attests below 30% patient volume, the Pre-Payment Auditor reviews documentation for the pediatrician. When a group attests below the 30% patient volume threshold, the group may only consist of pediatric providers under the definition established for the program.

4.6.4 Hospitals

The IME calculates the hospital payment based on a template spreadsheet found on the IME HIT and Promoting Interoperability website. The auditable data source for the hospital-specific entries is typically the hospital's submitted Medicare cost report. For purposes of calculating the Medicaid share, a patient cannot be counted in the numerator if they would count for purposes of calculating the Medicare share. Therefore, the inpatient bed day of a dually eligible patient cannot be counted in the Medicaid share numerator. In addition, nursery and swing bed (skilled nursing) days are not counted in the discharge number for purposes of calculating the incentive payment amount.

The hospital formula in PIPP is automated to ensure payments are made according to the statute and regulations. In verifying hospital data, the IME will depend on the following data sources:

- Provider's cost reports
- Payment and utilization information from the MMIS
- Hospital financial statements and hospital accounting records

The requested data for hospital discharges is based on the previous hospital fiscal year.

The IME pays hospitals on a three-year basis, with 40% of the payment in year one, 40% of the payment in year two, and 20% of the payment in year three, assuming the hospital meets the patient volume threshold and eligibility requirements are met each year, and meaningful use requirements are met for the applicable years. In the event there is a significant error to the hospital numbers that requires a recalculation of the incentive payment amount, the IME is willing to re-visit the initial payment amount determined in the year one participation year. However, IME will not re-calculate the payment for hospitals who want to re-calculate their payment simply because they would have received a higher amount if they had waited for a later payment year. The IME has provided on the HIT and Promoting Interoperability Program webpage a "hospital calculator" worksheet to assist hospitals with the payment calculation as well as a tip sheet.[49]

Eligible hospitals are first required to attest to Medicare for their Meaningful Use Measures. Iowa relies on the data that Medicare sends via the NLR and does not require that Eligible Hospital re-enter their meaningful use data into the PIPP

[49] See HIT and Promoting Interoperability website for Tools for Eligible Hospitals (EHs) https://dhs.iowa.gov/ime/providers/tools-trainings-and-services/medicaid-initiatives/EHRincentives

attestation system. In accordance with the deeming requirements of the final rule, if Medicare approves meaningful use payments to hospitals, Medicaid will accept the finding of meaningful use through Program Year 2015. Due to a program change by CMS, beginning with Program Year 2016 attestations the IME implemented an enhancement to the PIPP system which captures and requires hospital meaningful use and eCQM documentation uploads by the hospital along with the information that is shared over from Medicare.

The prepayment auditors review all attestation information, including documentation and attestation information on the MU and eCQM page, prior to payment. Hospitals attest that average length of patient stay is 25 days or fewer. IME validates the patient volume threshold and average length of patient stay requirements for eligible hospitals, as well as the hospital payment calculations.

Although the majority of Iowa hospitals had already received all three incentive payments prior to Program Year 2016, eleven hospitals initiated participation in the Iowa Medicaid Promoting Interoperability Program in 2016, and four hospitals received their third and final payment in Program Year 2016. As of April 2019, the IME has completed payment of the incentives to all hospitals participating in the Promoting Interoperability Program. See section 2.1.3 for more information.

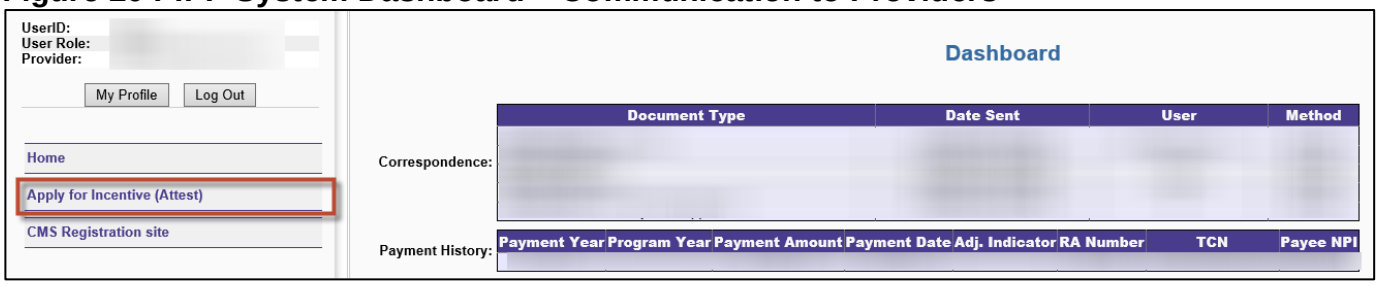
4.6.5 Payment Frequency

Once approved, incentive payments are issued from MMIS as part of the weekly payment cycle. Most providers receive their payments within 30 days of successfully completing the registration and attestation requirements.

4.6.6 Communication to Providers Regarding Eligibility, Payments, etc.

The PIPP system has a dashboard screen which displays any email communications sent to the email address registered with the CMS R&A system, the status of the attestation payment history, and any additional guidelines for completing the attestation.

Figure 20 PIPP System Dashboard – Communication to Providers



4.7 Systems

Iowa is committed to the use of electronic tools to support the outreach, communication, application and processing of the Electronic Health Record incentive program.

In late 2011, IME procured the Provider Incentive Payment Program (PIPP), for supporting administration of the EHR incentive payment program. PIPP launched on April 2, 2012. Providers begin the registration process through the CMS registration and attestation site, and complete the attestation process through PIPP. Applications are tracked and processed through PIPP and electronic payments are made through the Iowa Medicaid Management Information System (MMIS). Two separate documents have been provided to CMS unattached to this overall SMHP describing the PIPP system process workflows titled Appendix 1 and Appendix 2.

4.7.1 CMS Registration and Attestation Site

This CMS system provides the registration for provider applications and ensures no duplicate payments between Medicare and the State Medicaid agencies. Iowa successfully completed testing of all files from CMS, including those around Medicare cost reports and meaningful use data and has been receiving registration files from the site since January 3, 2011.

4.7.2 PIPP System Updates

The IME regularly updates the system to meet the criteria of the Promoting Interoperability Program. The IME has completed program updates within the PIPP system to comply with rule changes as they arise. The PIPP system is enhanced for reporting or workflow needs, and releases also contain other system fixes. The following table provides a summary of recent releases.

Table 6 PIPP System Releases

PIPP System Releases	
Release	**Implementation Date**
2.6	1/28/2017
2.6.1	2/18/2017
3.0	4/1/2017
3.1	7/1/2017
3.2	8/9/2017
3.2.1	8/29/2017
3.2.2	9/16/2017
3.3	11/11/2017
3.4	2/3/2018
3.4.1	4/14/2018
3.5.0	8/18/2018
3.5.1	10/20/2018
3.6	12/1/2018
3.7	1/9/2019
3.8	10/22/2019
3.9	12/28/2019
3.10	6/30/2020

4.7.2.1 System Updates/Enhancements

The PIPP system has continued to evolve over the years of the Promoting Interoperability Program to comply with program modifications. The IME has also performed system enhancements to improve the end user experience, communications and workflow with providers, and address program reporting needs. As program requirements have changed, the IME has submitted SMHP Addendums describing system updates and implementation to meet the Promoting Interoperability Program requirements. Other system enhancements and updates are noted below.

November 2016 the PIPP system was enhanced to require providers upload their Security Risk Assessment as part of the attestation process. This assists providers who may be selected for post pay audit having their documentation already in the PIPP system. The system was updated to increase the file size upload limitation for supporting documentation.

The PIPP system was enhanced in January 2017 adding a provider requested feature on the Meaningful Use questions screen to save, add a document, or cancel to the top of the screen. This enhancement saves time during the attestation process, as the MU screen can become quite long. The provider no longer has to scroll all the way to the bottom of the screen to perform these activities.

The PIPP system was enhanced in January 2017 so that the prepayment auditor workflow and communication to providers became more streamlined, emailing directly from the PIPP system to the provider as the attestation was reviewed, still

utilizing the same components for the email communication, the imeincentives email and the provider's email address from the CMS R&A system. The workflow was also enhanced giving the prepay auditor the capability review and make contact notes for a provider without going to a different screen. The email templates were updated during this timeframe to provide further guidance on the reasons the attestation was returned to the provider, and the prepay auditor gained the capability to modify and add to the templates to make the communication very specific to the issues for the particular attestation.

PIPP system functionality and reporting capabilities were enhanced in 2015 – 2018.

- CEHRT report
- CMS MU Payment Penalty Report
- Automated Risk Assessment
- Returned Application Report (used for provider outreach purposes)
- Status Report
- Dashboard report modifications

4.7.3 CMS Dependencies

4.7.3.1 Promoting Interoperability Program PIPP System

The IME is dependent on CMS, ONC, and other rules to be finalized so the PIPP system can be updated to be compliant with the Promoting Interoperability Program. The dependencies include:

- CEHRT rules
- eCQM updates per the eCQI timeline50
- Promoting Interoperability Program rule changes (i.e. reporting periods, eCQM additions or removal, etc.)
- Other program(s) rule changes impacting the Promoting Interoperability Program

4.7.3.2 Medicaid Enterprise Systems Dependencies

As CMS and ONC implement rules requiring HIT and electronic health information exchange, the IME must first focus on the MMIS Modernization project so systems have capabilities to accommodate policy changes. As the systems are modernized the IME can implement quality strategies which are capable of incorporating electronic quality measures, such as the eCQMs of the Promoting Interoperability Program.

4.7.4 Medicaid Management Information System (MMIS)

The MMIS system manages the provider data store, adjudicates claims, and makes payments. All payments are made on a weekly basis through the use of Electronic File Transfers (EFT). A special provider type was added to support the EHR incentive payment program to aid in tracking and incentive payment issuance.

[50] eCQI Annual Timeline https://ecqi.healthit.gov/ecqm-annual-timeline

4.8 MMIS Enhancements

MMIS was enhanced to support issuing payments to providers who qualify for the Promoting Interoperability Program. A provider type (provider type 66) was created to indicate a provider file created solely for purposes of the incentive payment program. The creation of a separate provider type was necessary to ensure incentives are accounted for separately from claims in the MMIS system.

EHR incentive payments appear on the remittance advice statement along with other regularly paid claims, but with a code indicating an EHR payment. A new EOB code was added to indicate the payment is attributable to the EHR incentive payment program.

Medicaid payments to providers are paid through the MMIS. The payments are made directly to the provider, or to an employer or facility to which such the EP has assigned payment without any deduction or rebate.

The MMIS reports used to support the CMS-64 and claiming for federal funding of the incentive program have been modified to separately identify the incentive payments.

The IME issues incentive payments to providers according to its regular weekly payment schedule.

The IME has the following assumptions and dependencies:

- The IME receives daily batch updates from the CMS NLR
- IME has access to view information in the NLR with look-up capability for the IME to check the status of any given provider
- The IME expects timely reimbursement, or advance payment, from CMS in alignment with the payment schedule to providers
- The IME's anticipated challenges include operating under budget constraints, numerous other initiatives, and staff reductions

The IME receives the following data elements from the CMS NLR daily batch:

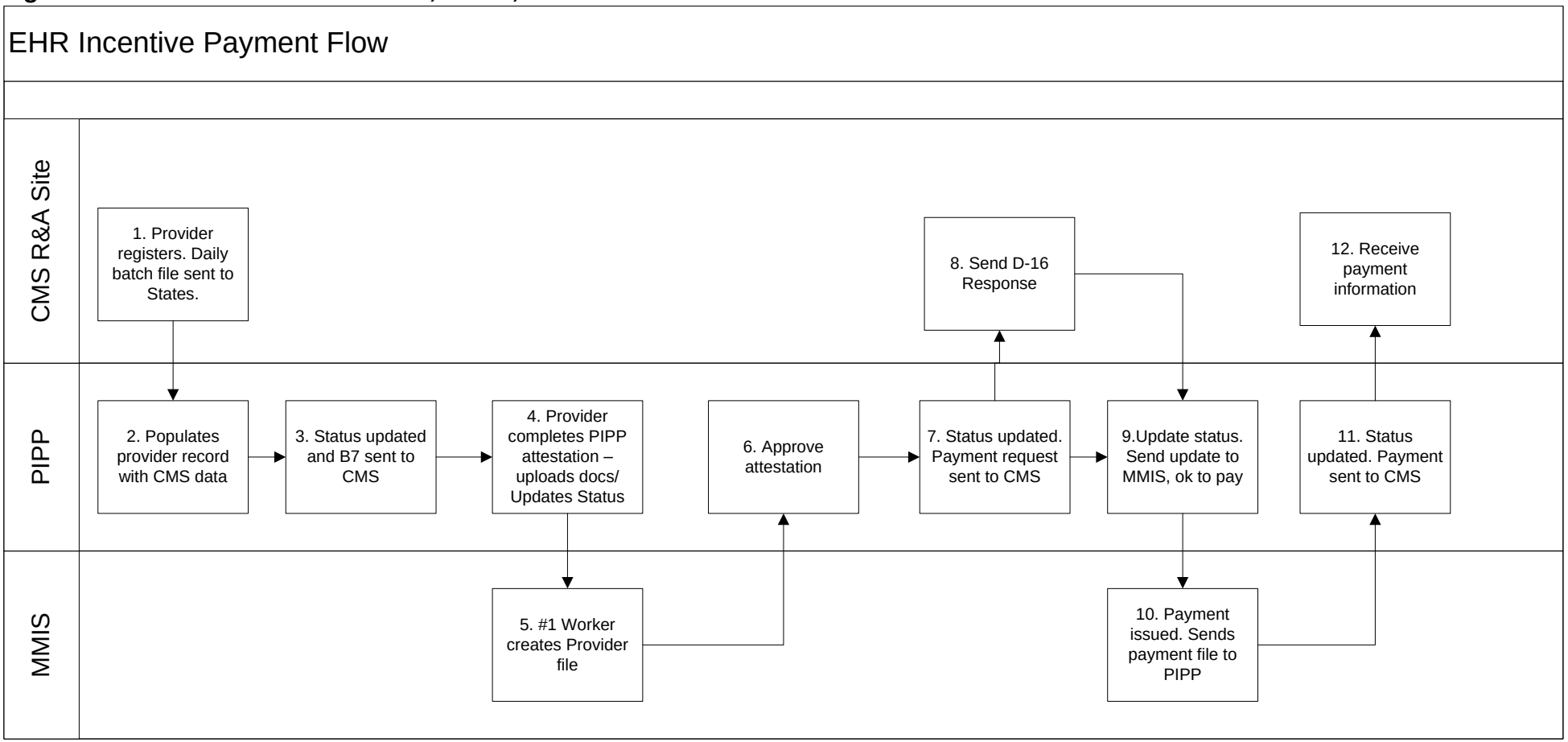
- Provider name
- Provider individual NPI
- Provider type
- Provider business address
- Provider business email address
- Provider business phone
- TIN to which the provider wants the payment made
- CCN for eligible hospitals
- Provider registration number

The IME SLR sends to CMS the following data elements:

- Amount of payment (if a previous payment was made from Medicare or another state)
- Date of payment (if a previous payment was made from Medicare or another state)
- Reason codes for ineligibility (if previously denied by Medicare or another state)

A diagram showing the workflow interaction between these systems is found on the next page.

Figure 21: Workflow between PIPP, MMIS, and CMS



4.9 Appeals

The existing provider appeals process was expanded to include appeals from providers on the basis of the incentive payment amount, provider eligibility determinations and demonstrations of efforts to adopt, implement or upgrade and meaningfully use certified EHR technology. In 2010, the IME adopted an administration rule to support the appeals process. The rule was amended in early 2011 to include the definition of pediatrician. Because IME must include the attestation questions as part of the rule, the rule was amended July 2013 to include questions on meaningful use and to clarify the timeframe for hospital patient volume.

The appropriate IME unit tasked with tracking the appeal depends on the basis for the appeal. Provider Services will handle provider contests to eligibility determinations. The Program Integrity unit will handle contests based on post payment findings of A/I/U or meaningful use. To date, there have been few appeals filed as a result of the EHR incentive payment program. The IME expects providers to contact the IME prior to initiating a formal appeal. The IME will work with providers to resolve issues without the need for using the appeals process.

The Manage Provider Grievance and Appeals business process handles provider appeals of adverse decisions or communications of a complaint or grievance. A complaint, grievance or appeal is received by the Manage Provider Communication process via the Receive Inbound Transaction process. The complaint, grievance or appeal is logged and tracked; triaged to appropriate reviewers; researched; additional information may be requested; an appeals hearing is scheduled and conducted in accordance with legal requirements; and a ruling is made based upon the evidence presented. Results of the appeals hearing are documented and relevant documents are distributed to the provider information file. The provider is formally notified of the decision via the Send Outbound Transaction Process.

This process supports the Program Management Business Area by providing data about the types of complaints, grievances and appeals it handles; complaint, grievance and appeals issues; parties that file or are the target of the complaint, grievances and appeals; and the dispositions. This data is used to discern program improvement opportunities, which may reduce the issues that give rise to complaints, grievances and appeals.

Figure 22: Appeals Process Flow

Appeal Process

Table 7: Appeal Process Narrative

Step	Action
1	Provider files notice of appeal by one of three mechanisms: Complete an appeal electronically at https://dhssecure.dhs.state.ia.us/forms/appealrequest.htm, or Write a letter telling us why you think a decision is wrong, or Fill out an *Appeal and Request for Hearing* form. The IME expects providers to contact the IME prior to initiating a formal appeal. The IME will work with providers to resolve issues without the need for using the appeals process. IME staff have reached out to denied providers to explain the reason for denial, as well as options for re-applying.
2	Provider contests eligibility determination? Providers may be denied eligibility for the incentive program if they do not meet the minimum patient threshold or if they are not the correct provider type. Providers may contest this finding.
3	Provider contests A/I/U or MU finding? Providers may be denied incentive payments on the basis they did not successfully demonstrate efforts to adopt, implement or upgrade, or to show meaningful use. Providers may contest this finding.
4	Provider contests payment? The amount providers are paid is based on their participation year, whether the provider is a pediatrician, and possibly other factors, particularly with the hospital payment formula. Providers may contest this finding.
5	Verify disputed issue. Providers must submit documentation to support their claim. This documentation is researched to determine whether the IME decision is found to be correct. Providers may appeal that the process was not followed, but cannot appeal the process itself.
6	Go to existing payment appeal process. This is the existing process for responding to provider appeals.

4.10 Claiming FFP

The IME provides assurances that amounts received with respect to sums expended that are attributable to payments to a Medicaid provider for the adoption of EHR are paid directly to the provider, or to an employer or facility to which the provider has assigned payments without any deduction or rebate.

This section describes the process for ensuring no more than 100% FFP is claimed for reimbursement of incentive payments made to providers, and that no more than 90% of FFP is claimed for the administrative costs of administering the program. These steps leverage existing processes followed for claiming FFP for Medicaid expenditures.

Figure 23: Claim Federal Reimbursement Flow

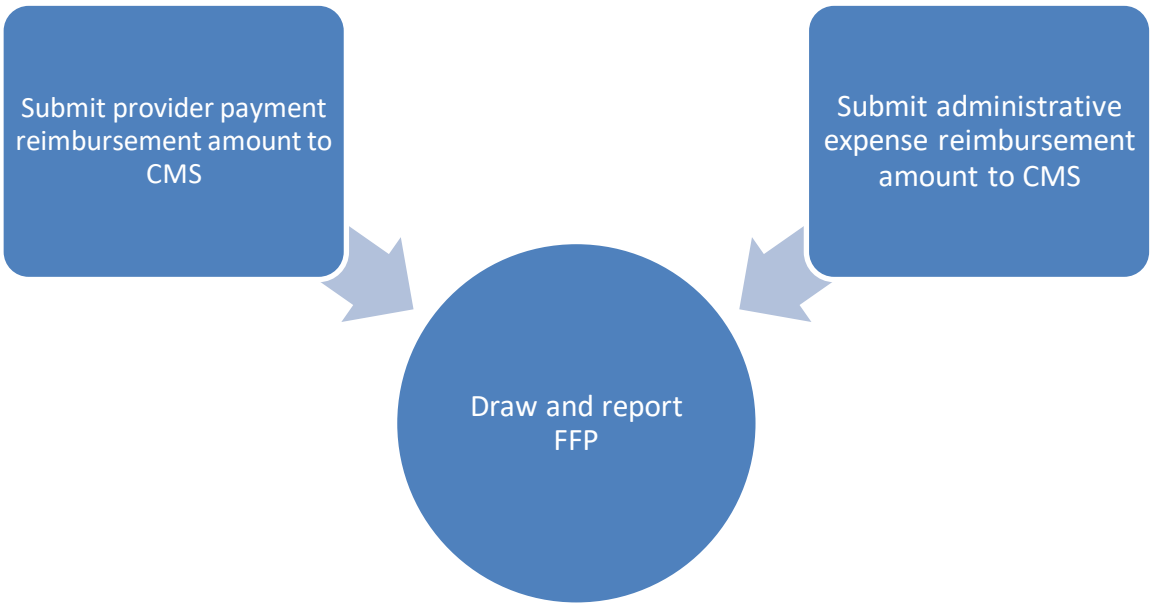


Table 8: Claim Federal Reimbursement Narrative

Step	Action
1	495.332(c)(7) a description of the process in place to ensure that no amounts higher than 100 percent of FFP will be claimed for reimbursement of expenditures for State payments to Medicaid EPs for the incentive program and a methodology for verifying such information is available. Payments claimed will be consistent with the guidance provided in SMD# 10-016.
2	495.332(c)(7) a description of the process in place to ensure that no amounts higher than 90 percent of FFP will be claimed for administrative expenses in administering the incentive program and a methodology for verifying such information is available. The CMS-64 forms provide lines for the reporting of HIT administrative activities reimbursable at 90% (Lines 24A – 24D)

The state is responsible for assuring that the correct FFP rate is applied to all expenditures in determining the amount of federal funds to draw. When CMS has approved the Advanced Planning Document, the state draws quarterly to cover the federal share. The funding authorizes the state to draw federal funds to pay the federal share of disbursements, and federal share of expenditures for services, training, and administration. The state receives federal financial participation in expenditures.

CMS can increase or decrease funding because of an underestimate or overestimate for prior quarters. FFP for items requested within the Advanced Planning Document can be deferred or disallowed if CMS determines that the FFP is incorrectly reported or is not a valid expenditure.

4.11 Promoting Interoperability Program Sunset Activities

The following table provides a timeline of activities the IME program staff will perform to sunset the program.

Promoting Interoperability Program Project Closeout Activities	End Date
Incentive Payments Complete	12/31/2021
Prepay Audit Closeout	12/21/2021
Final Environmental Scan & SMHP	3/31/2022
PIPP System Closeout	6/30/2022
Post Payment Audit and Appeals Closeout	6/30/2022
Program Administration/Oversight Closeout	9/30/2022
Document Repository Archived for Historical and Auditing Purposes	9/30/2022
SLR Data Archived for Historical and Auditing Purposes (payments, attestation, supporting documentation, audits, appeals, system manuals)	9/30/2022
SLR Disconnect from NLR Complete	9/30/2022

5 Section E: Iowa's HIT Roadmap

5.1 Overview

Iowa's HIT Roadmap provides a graphical and narrative pathway which describes the overall journey to achieving the To-Be vision (Section 3).

5.2 Description of Pathway

The IME's focus remains on managed care implementation and onboarding, MMIS modernization with a modular approach, improved data analytics, improving member healthcare outcomes, and alternative payment models. The IME continues to administer the Iowa Medicaid Promoting Interoperability Program for the meaningful use of EHRs by Eligible Professionals and Hospitals.

The IME continues to be involved with discussions on electronic health information exchange of patient data among Iowa's health care providers, thereby improving the quality and efficiency of care received by all Iowans through the Governor's Healthcare Innovation and Visioning Roundtable. The IME's Medicaid Director is a board member of the state's designated HIE non-profit entity, the IHIN, as directed by Iowa code 135D.

The IME will support the To-Be goals as outlined in Section 3:

- Support the Adoption of Electronic Health Records and Health Information Exchange
- Improve Administrative Efficiencies and Contain Costs
- Improve Quality Outcomes for Members
- Improve Member Wellness

By:

- Modernizing and Transforming the MMIS
- Administering the Medicaid Promoting Interoperability Program
- Supporting Health Information Exchange through:
    - Promoting Interoperability Program requirements
    - Environmental Scan and/or Surveys
    - Iowa code 135D
    - Governor's Healthcare Innovation and Visioning Roundtable

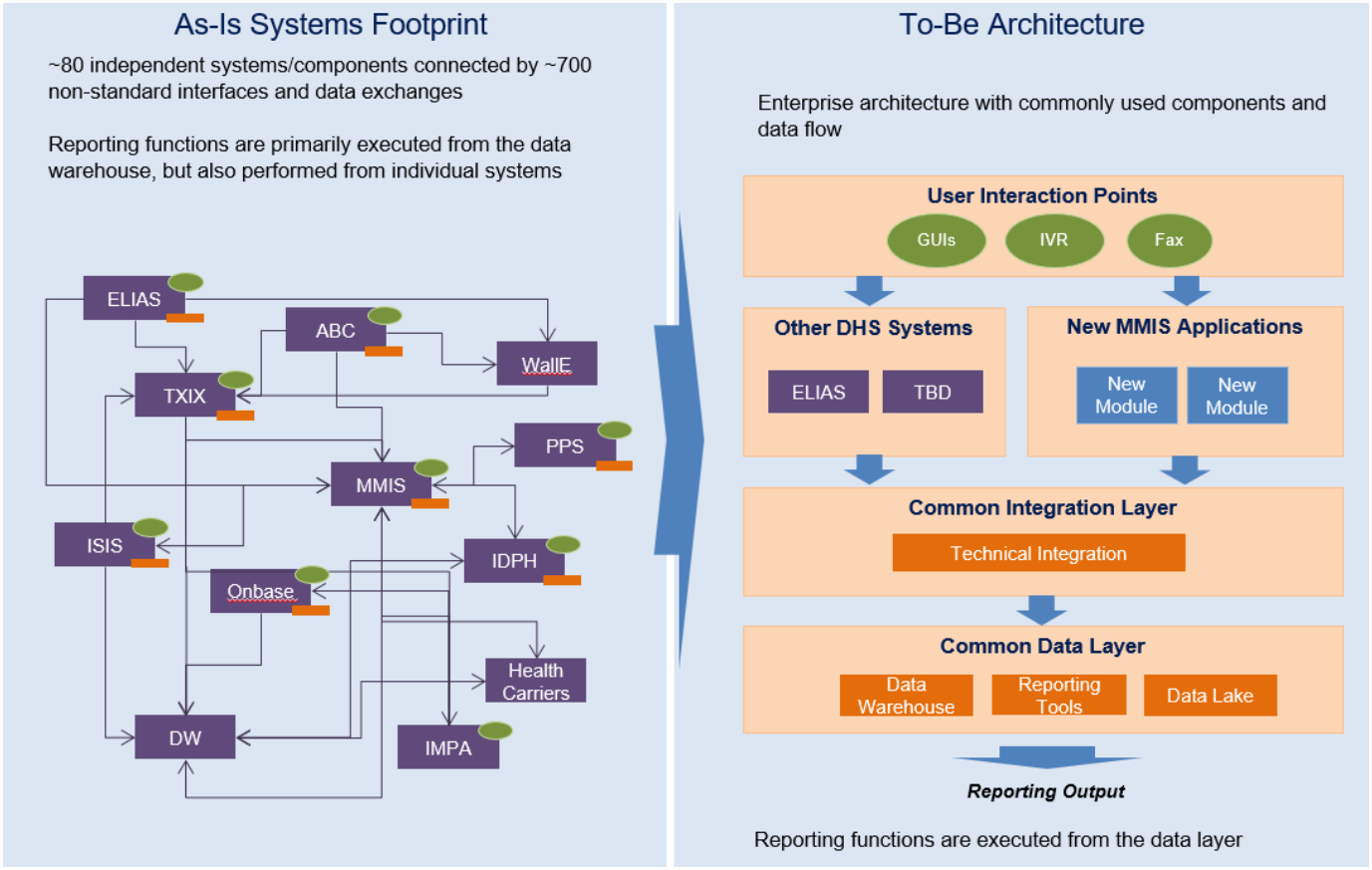
5.2.1 Modernizing and Transforming the MMIS

The IME's HIT Roadmap focuses on modernizing and transforming the MMIS so it is capable of achieving the To-Be goals:

- Support the Adoption of Electronic Health Records and Health Information Exchange
- Improve Administrative Efficiencies and Contain Costs
- Improve Quality Outcomes for Members
- Improve Member Wellness

The IME is starting from the As-Is state with an antiquated MMIS system. The future state entails fully replacing a large number of legacy systems and interfaces, creating a member portal, and a robust enterprise data warehouse. With data and analytics maturity, the IME will improve capabilities to perform predictive modeling, risk analysis and mitigation, and data for strategic planning. The conceptual MEME implementation approach from current state to future state is pictured below, as presented in the RFI[51].

Figure 24 Conceptual MEME Implementation Approach – Current State to Future State



5.2.1.1 Modernizing and Transforming MMIS Benchmarks

Key Performance Indicators (KPIs) and Benchmarks will be described through the MEME project and associated IAPD Updates. The project will be rolled out in a phased approach. The implementation strategy is described in the RFI, and will be updated as part of the MEME project and process with CMS. The Agency plans to procure the modules required to support business processes then add subsequent modules and components as needed to support each new phase of delivery.

[51] MED 19-029 RFI https://bidopportunities.iowa.gov/Home/BidInfo?bidId=bd232a61-9fcd-418e-a1fc-75dcd36220b1

5.2.2 Administer Medicaid EHR Incentive Payment

The foundation of a more efficient healthcare delivery system starts with Iowa's providers and their adoption of Electronic Health Records. The IME implemented the appropriate EHR incentive payment systems and procured software to capture the attestations online. This software became available on April 1, 2012, the earliest date EPs could apply for year two incentive payments. The IME continues to administer the incentive program, and performs system updates as appropriate per the Promoting Interoperability Program rules.

We continue direct outreach efforts to providers eligible to return for incentives. The IME offers a website with up to date program information and helpful tools, including guidance on how to calculate and document patient volume. We want to ensure providers are able to successfully understand the requirements for attestation and complete the application the first time around.

5.2.2.1 EHR Adoption and Benchmarks

See section 2.1.3 for information specific to EHR adoption and targets within the IME Promoting Interoperability Program. Targets for the remaining years may result in lower numbers than predicted due to:

- Providers not able to meet Stage 3 requirements
- Organizations are focusing on other programs (QPP, etc.)
- Although the QPP Promoting Interoperability components are similar they are not the same, which in turn means more investment in producing reports that meet multiple program reporting requirements
- The Medicaid PI Program requirements do not have the same exclusions as the QPP program
- The Medicaid PI Program contains patient volume threshold and reporting requirements
- Organizations may not view the remaining incentives for providers who have not topped out as a priority and may view the attestation process as a burden
- The Medicaid PI Program has a pre-pay audit process which requires documentation supporting the attestation prior to payment

5.2.3 Support Health Information Exchange

As Iowa's providers adopt EHR Technology, the IME supports the Promoting Interoperability Program and the exchange of health information.

The IME has participated in the planning of a statewide health information network, IHIN. The first build of IHIN was through Iowa eHealth, led by the Iowa Department of Public Health and under the direction of the eHealth Executive Committee and Advisory Council. Iowa Medicaid Enterprise (IME) participated in the Executive Committee, Advisory Council and workgroups to ensure the unique needs of the Medicaid population and Medicaid program were considered. This model restricted the IHIN from creating or utilizing a repository model for exchange.

The change to a private non-profit entity occurred March 31, 2017, and Iowa code 135D provides direction as described in Section 2 of this document. The restriction of a federated model was lifted, and the new IHIN non-profit was able to build a new platform with both centralized and federated options for participants. The Iowa Health Information Technology Implementation Advance Planning Document Update (HIT IAPD-U) was approved by CMS effective March 28, 2018 through September 30, 2019, to support the build of the new platform, onboard participants, and continue public health registry build and connections. The IHIN completed the build of the new platform during this timeframe. In February 2020, IME submitted an HIE IAPD and it was approved by CMS to support platform on-boarding, EHR interface development, and other HIE services implementation activities with an effective date of March 2, 2020, however, to date no contract has been executed for the scope of work. More information regarding the IHIN and the IHIN's utilization metrics are posted to their website[52]. Iowa code 135D[53] provides guidance on principles, administration, and governance of the non-profit. Specifically:

> 135D.4(2) Widespread adoption of health information technology is critical to a successful Iowa health information network and is best achieved when all of the following occur:
> a. The network, through the designated entity complying with chapter 504 and reporting as required under this chapter, operates in an entrepreneurial and businesslike manner in which it is accountable to all participants utilizing the network's products and services.
> b. The network provides a variety of services from which to choose in order to best fit the needs of the user.
> c. The network is financed by all who benefit from the improved quality, efficiency, savings, and other benefits that result from use of health information technology.
> d. The network is operated with integrity and freedom from political influence.
>
> 135D.5(2). The designated entity shall collaborate with the department, but the designated entity shall not be considered, in whole or in part, an agency, department, or administrative unit of the state.
> a. The designated entity shall not be required to comply with any requirements that apply to a state agency, department, or administrative unit and shall not exercise any sovereign power of the state.
> b. The designated entity does not have authority to pledge the credit of the state. The assets and liabilities of the designated entity shall be separate from the assets and liabilities of the state and the state shall not be liable for the debts or obligations of the designated entity. All debts and obligations of the designated entity shall be payable solely from the designated entity's funds. The state shall not guarantee any obligation of or have any obligation to the designated entity.

[52] IHIN metrics https://www.ihin.org/article/ihin-utilization-metrics
[53] Iowa Code Chapter 135D https://www.legis.iowa.gov/docs/code/135d.pdf

135D.5(3)e. The financial operations of the designated entity including the authority to receive and expend funds from public and private sources and to use its property, money, or other resources for the purpose of the designated entity.

The most recent Iowa Health Information Technology Implementation Advance Planning Document Update (HIT IAPD-U) was submitted by the IME on August 21, 2020. The request is for continued support of public health registry connections and onboarding. The build and onboarding activities directly support the public health reporting requirements under the Promoting Interoperability Program. The IME determined in order to meet the current needs of Iowa and continue to support MU through enhanced interoperability and bi-directional exchange, it will work with Iowa Department of Public Health to continue to enhance electronic reporting capabilities.

In order to best support the Medicaid Promoting Interoperability Program requirements, and the desired Public Health connectivity; the funds requested through the IAPD-U will be used to support activities for Electronic Initial Case Reporting (eICR), electronic lab reporting (eLR), immunization registry (IRIS), and provider connections to each of the Public Health registries. IME will continue to coordinate with the Governor's Roundtable, IHIN, and Iowa Department of Public Health, to assess the HIT landscape and systems functionality across Iowa.

The IAPD-Update also requests funding for a final program environmental scan.

5.2.3.1 Health Information Exchange Benchmarks

The HIE activities supported through the IAPD funding will conclude September 30, 2021. Results of the planning activities may result in updates to the applicable Medicaid Enterprise Systems IAPD-Updates to incorporate items identified as beneficial and sustainable to the MES.

Benchmarks for the Public Health Registry Activities
Electronic Case Reporting:

- Onboarding ongoing through September 2021
- 60 hospital/lab facilities and 200 clinic site addresses will be onboarded by September 2021

Electronic Lab Reporting

- Implement receiver by October 2019
- Onboard ELR Participants to IDPH receiver by September 30, 2021
- Onboard 95/95 ELR participants by September 2021
- Transition eLR hosting to IDPH AWS environment

Immunization Registry

- Onboard health care providers conducting bidirectional data exchange with IRIS, increase connections by 5% by September 1, 2021

- Implement Recall IRIS Functionality by providing 24 Technical Assistance webinars by September 30, 2021
- Implement IRIS Public Access Feature for Medicaid Members by September 1, 2021

Benchmarks for Planning Activities
Environmental Scan – through 12/31/2021

- Create tools to collect information
- Conduct interviews and surveys to inventory and assess impacts of the Promoting Interoperability Program which could include topics such as current technical capabilities, tools in use, and reporting/data collection methods.
- Analyze information collected to inform on Iowa's HIT Landscape

5.3 Evolving HIT/E Roadmap

At the Federal level, there have been efforts of alignment of the Promoting Interoperability Program, quality measures through the Meaningful Measures Framework, and continued efforts to reduce administrative burden. Overall, health information exchange is making advancements through HL7 FHIR implementation guide advancements, the draft releases of TEFCA, ONC's final rule of the 21st Century Cures Act Interoperability, Information Blocking, and HIT Certification Program; and CMS' Interoperability and Patient Access final rule. National goals of interoperability are far reaching with not only specific providers sharing data who are impacted by the Promoting Interoperability Program, but all healthcare providers, payers, clinical research access to health information, and ultimately the patient/beneficiary's access to their own health information. HIT/E are even further reaching as care coordination incorporates Social Determinants of Health. As the Trusted Exchange Framework and Common Agreement are finalized, they will provide the IME more guidance on both data and technical governance and legal governance; and a broad data sharing path forward. Implementations of APIs for both payers and providers through various regulatory requirements are assisting in moving interoperability of health information forward.

Over the past decade health information technology and exchange has evolved, and continues to evolve as technology advancements are made. With various rules being finalized and those which remain un-finalized, incorporating health information technology and exchange requirements within them, the Medicaid Enterprise Systems will continue to evolve to meet the policy requirements.

6 Appendices

6.1 PIPP System Workflows

See separate documents titled

- Appendix 1 - Payment Processing Workflows
- Appendix 2 - IME PIPP Workflows